

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First <u>Robert</u> Middle <u>Adams</u> Last <u>Adams</u>						2a. DATE KNOWN OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1968</u>			2b. HOUR M <u>34</u>			
3. SEX <u>M</u>		4. RACE <u>C</u>		5. DATE OF BIRTH <u>unknown</u>		6. AGE (In years last birthday) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>		
7a. BIRTHPLACE (State or foreign country) <u>unknown</u>			7b. CITIZEN OF WHAT COUNTRY? <u>unknown</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Harford</u>			
10. CITY OR TOWN OF DEATH <u>Harford</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>unknown</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>unknown</u>				13b. COUNTY <u>unknown</u>		13c. CITY OR TOWN <u>unknown</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>unknown</u>		
14. FATHER'S NAME First <u>unknown</u> Middle <u>unknown</u> Last <u>unknown</u>				15. MOTHER'S MAIDEN NAME First <u>unknown</u> Middle <u>unknown</u> Last <u>unknown</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic EV disease</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>												
19a. DATE OF OPERATION <u>12-20-68</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>unknown</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>unknown</u>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>unknown</u>				21f. LOCATION Street or R.F.D. No. <u>unknown</u> City or Town <u>unknown</u> County <u>unknown</u> State <u>unknown</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/As md.</u>				22b. DATE SIGNED <u>12-20-68</u>				
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county) <u>unknown</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>unknown</u>		23b. DATE <u>12-20-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>C. of Ind. Med. School Baltimore Md.</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>					
24. FUNERAL DIRECTOR <u>unknown</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 26 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item #2a File #4408 12/7 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17600									
1. DECEASED-NAME (Type or Print) <u>John Alcorace</u>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>not known</u> Day <u>19</u> Year <u>19</u>		2b. HOUR <u>M</u>	
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>May 26, 1905</u>		6. AGE (In years last birthday) <u>63</u> YRS.		7c. DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>14</u> Year <u>1968</u>	
7a. BIRTHPLACE (State or foreign country) <u>Unknown</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u>		2d. HOUR <u>252</u> M	
10. CITY OR TOWN OF DEATH <u>Hanover</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Dorchester Memorial Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Boxer</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Cecil</u>		13c. CITY OR TOWN <u>Perryville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>M. H. Crank Rd.</u>	
14. FATHER'S NAME First <u>Unknown</u> Middle <u></u> Last <u></u>				15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS <u>Md. State Police Investigation Record</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u></u>		City or Town <u></u>		County <u></u> State <u></u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Leroy E Palmer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>12-14-68</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/19/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		23d. LOCATION (City or Town) <u>Elkton, Md.</u>		(County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>				ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. RECEIVED BY REGISTRAR <u>DEC 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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VR A15ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
ANTHONY WILLIAM ALLGEIER						Month Day Year			8:20 A
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	May 30, 1922	46 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
BALTIMORE, Md		U.S.A.		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		HARFORD		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
FALLSTON			RD #1 Box 426 MONTE			ENGINEER SUPERVISOR JNGER, REC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md			HARFORD			FALLSTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			RD #1 Box 426 MONTE AVE.			
Frederick Allgeier			Rose Zellinger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
NO			212-12-7876			MRS NAOMI B. ALLGEIER (WIFE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY									INSTANT
4110 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) HYPERTENSION AND CARDIAC HYPERTROPHY									27 YRS
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. P.M.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Philip W. Heuman M.D.			M.D.			DEC 20, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
PHILIP W. HEUMAN M.D.						307 HICKORY, BELAIR			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			12-24-68		Belair Memorial Gardens		Belair Rd.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John C. Kellum Inc. - 6415			Belair Rd. - 21206			DEC 27 1968		Charles Judge	

In the County of ...
 State of New York
 I, the undersigned, Clerk of the Court of Sessions of the County of ...
 do hereby certify that the within and foregoing is a true and correct
 copy of the ...
 as the same appears from the records of the Court of Sessions of the County of ...
 this ... day of ... 19...
 Clerk of the Court of Sessions of the County of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17591										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17602									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) First Middle Last Eva Marie Balcer										2a. DATE OF DEATH Month Day Year December 21, 1968										2b. HOUR M									
3. SEX Female			4. RACE White			5. DATE OF BIRTH Dec. 1, 1892			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Bay City, Michigan			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford County, Md.																				
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 26 East Gordon Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Registered Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 26 East Gordon Street																	
14. FATHER'S NAME First Middle Last Andrew - Balcer					15. MOTHER'S MAIDEN NAME First Middle Last Veronica Kaczmarek																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-30-6394			17. INFORMANT (Name) - 313-EL6-1876 Address 21520 Indian Southfield, Michigan 48075																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, acute 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 5-10 years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 67 , to Dec , 19 68 , that (I) (we) lost the deceased alive on 17 Dec , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Charles Richardson			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Dec. 21, 1968																				
22d. PHYSICIAN'S NAME (Type) Charles Richardson, Jr., M.D.			22e. ADDRESS Bel Air Lee Med. Center, Bel Air, Md.			22f. ADDRESS 21014																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 23, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery			23d. LOCATION (City or Town) (County) (State) Bay City, Bay Co, Michigan																				
24. FUNERAL DIRECTOR Joseph William Foster			W. Broadway & Williams Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR DEC 24 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																				

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17502		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17603	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH 2b. HOUR	
Margaret Catherine Ballwin						Dec. Month 21 Day 1968 1:32A-M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Caucasian		10-12-02		100 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Harford Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Harre de Grace		Citizen Purcing Home		Housewife		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Harford		Harre de Grace		415 Warren St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
John WALLBILICK		JENNIE SCHMIDT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		214-12-0367		MRS FLORENCE M-LITTLE		50 SQUEHANNA, AVE PERRYVILLE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral Necrosis							
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Genitourinary tract infection							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1968, to Dec 20, 1968, that (I) (we) last saw the deceased alive on Dec 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Dante U. Monakil, M.D.							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
DANTE U. MONAKIL, M.D.		211 N. Union Ave. Harre de Grace Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		12-23-1968		MT. ERIN CEM.		HARREDEGRACE HARBOR, MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
K. Madron Mitchell		HARREDEGRACE MD.		DEC 24 1968		Charles Judge	

8317

STATE UNIVERSITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. **Three** please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV. 1/68

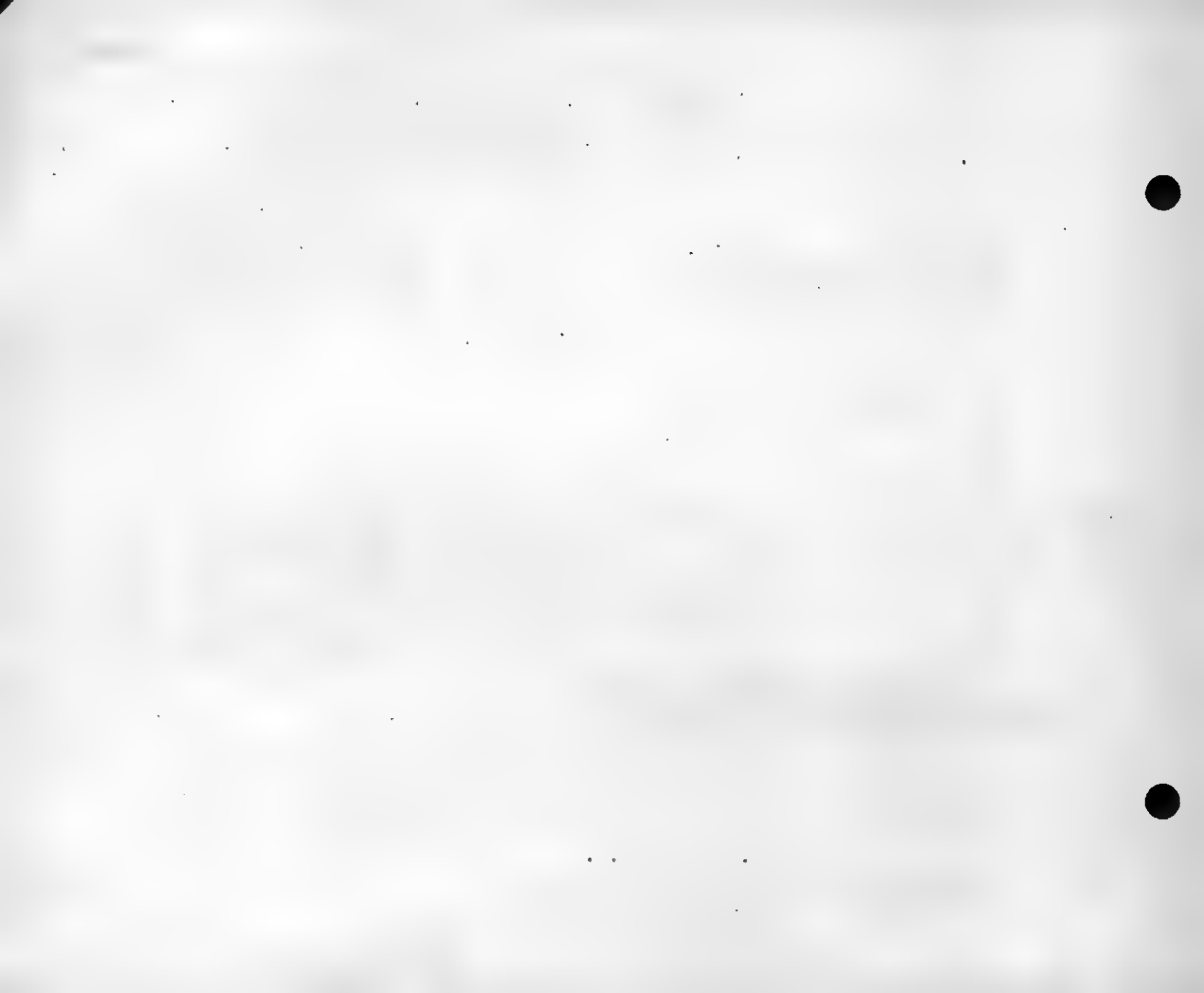
MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Baby First Boy Middle Bannon Last Twin B			2a. DATE OF DEATH Month 12 Day 5 Year 68			2b. HOUR 2:10 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 3/1968		6. AGE (in years last birthday) YRS. 2		IF UNDER 1 YEAR MONTHS 2 DAYS 2	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 136 N. Main ST.	
14. FATHER'S NAME First Norman Middle John Last Bannon Jr.			15. MOTHER'S MAIDEN NAME First Marie Middle Edith Last Narvell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Norman Bannon Jr. Port Deposit, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Respiratory distress syndrome									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Prematurity (Wt. 4-4)									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Baby was 2nd of 3 twins									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7735									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-3-1968 , to 12-5-1968 , that (I) (we) last saw the deceased alive on 12-5-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. B. Norment, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/5/68			
22d. PHYSICIAN'S NAME (Type) R. B. Norment, M. D.				22e. ADDRESS Harre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/7/68		23c. NAME OF CEMETERY OR CREMATORY Harmony Chapel Cem.		23d. LOCATION (City or Town) (County) (State) Liberty Grove Cecil, Md.			
24. FUNERAL DIRECTOR Lee H. Patterson & Son, Perryville, Md.				25a. REC'D BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21-5 Film 408 1-14 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17504 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17605									
1. DECEASED-NAME (Type or Print) First Middle Last Lovellia MAE Belcher						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> M			
3 SEX F	4 RACE W	5 DATE OF BIRTH 12/23/1918	6 AGE (in years last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Dec Day 31 Year 1968 2d. HOUR 6:30 P M			
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USJA. OCCUPATION (Kind of work done during most of work life, even if retired.) Asst. Hospital		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE W. Va.		13b. COUNTY McDOWELL		13c. CITY OR TOWN KEYSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last RILEY		15. MOTHER'S MAIDEN NAME First Middle Last ARVELLA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 817.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year 12-31-1968 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto accident					
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) US RE 1		21f. LOCATION Street or R.F.D. No Be/Ar)-H City or Town Harford County Harford State Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Belcher, Md.		ASS STANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 1-1-69			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/3/69		23c. NAME OF CEMETERY OR CREMATORY BEAMAN CEMETARY		23d. LOCATION (City or Town) KEYSTONE (County) W. VA. (State)			
24. FUNERAL DIRECTOR RALPH M REED		ADDRESS RISING SUN, MD		25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

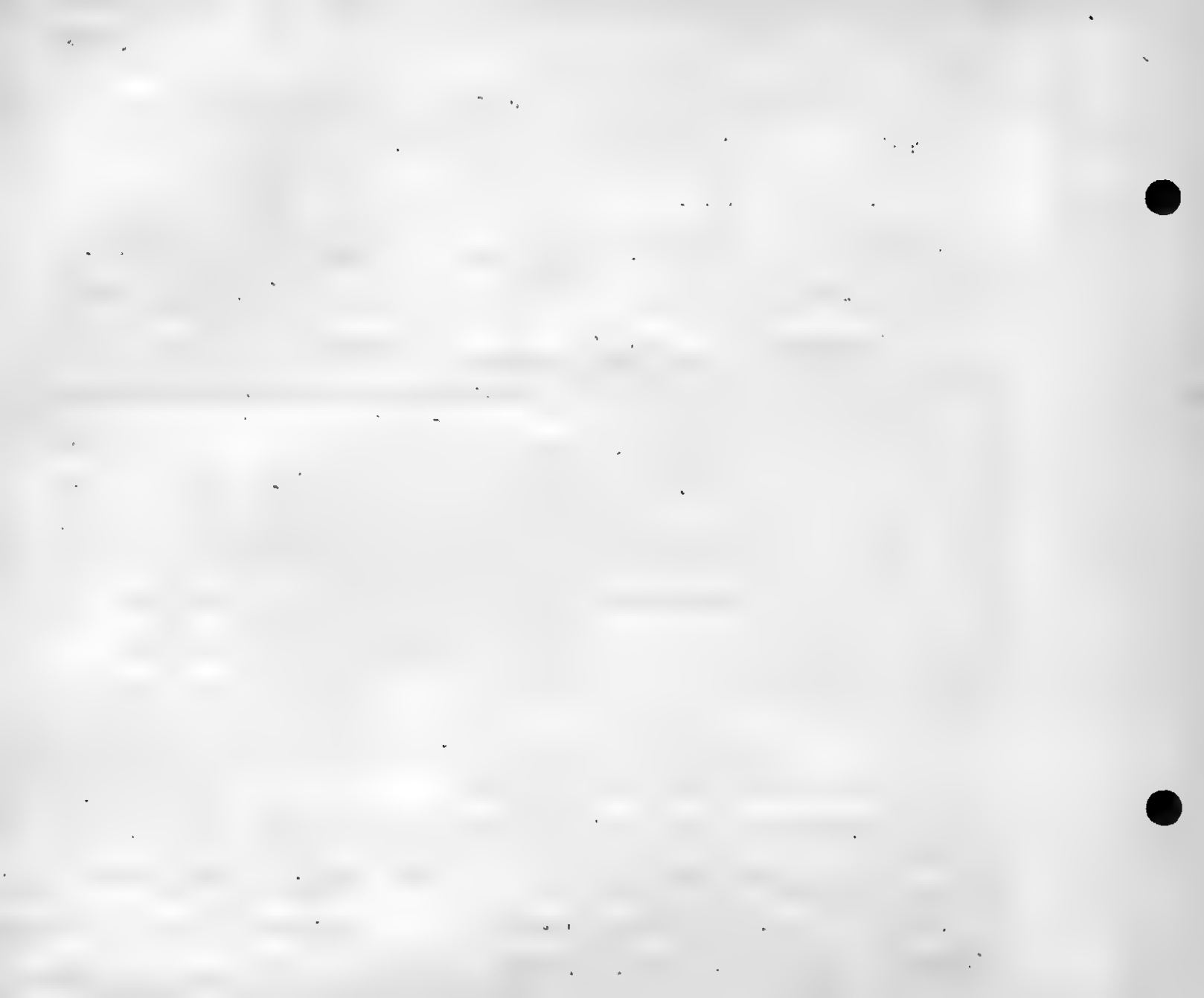


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 11-59

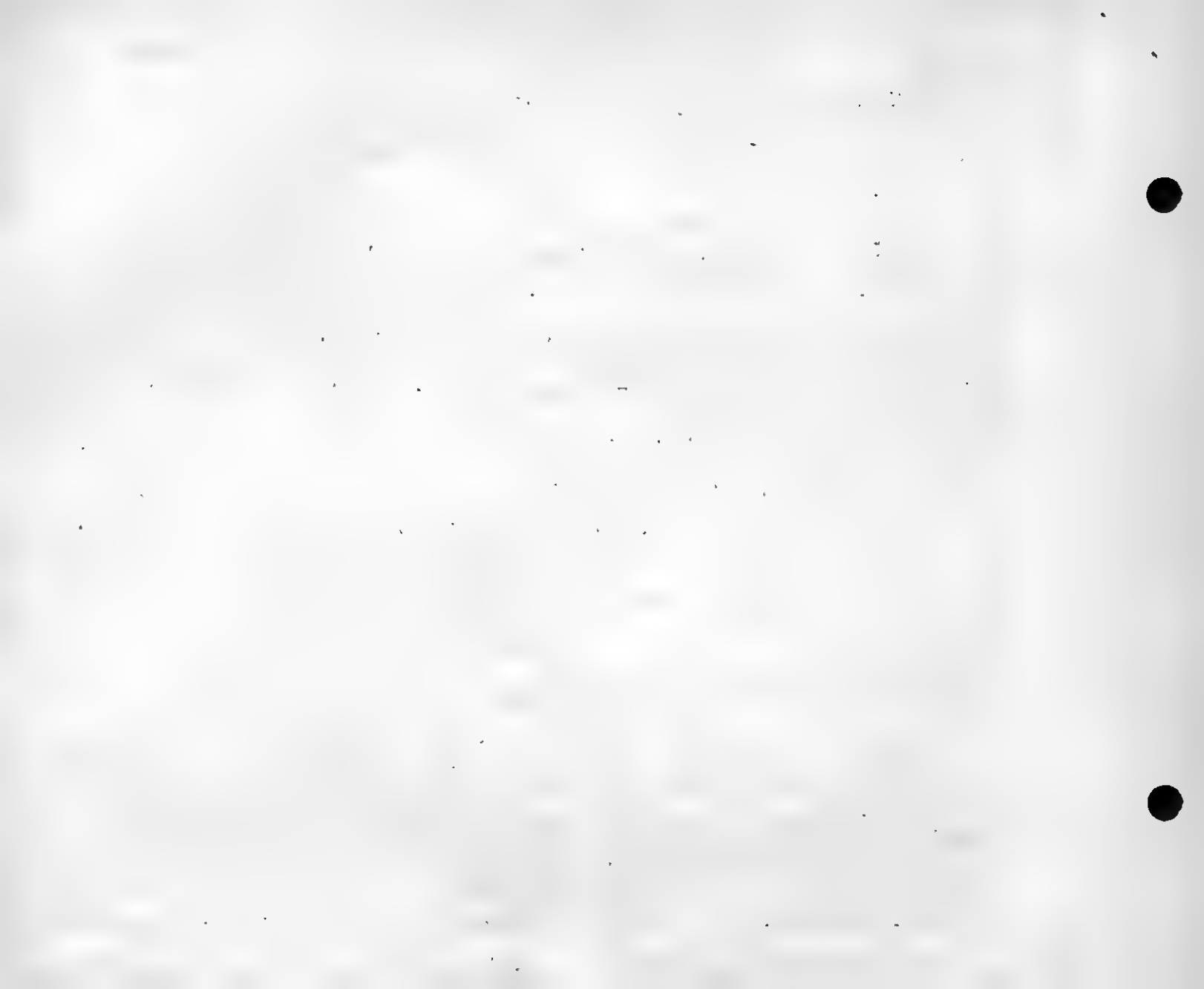
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>17595</div> <div>CERTIFICATE OF DEATH</div> <div>17606</div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
WILHELMINA			ROSE			December 5, 1968		2:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Caucasian		17 September 1878		90 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U.S.A.				Harford Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Aberdeen			476 W. Bel Air Avenue			Housewife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		476 W. Bel Air Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Constantine			Vogt (D)			Barbara Endress (D)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			** ** *		Agnes Berger, Aberdeen, Maryland 21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, et</u>									8 day	
DUE TO, OR AS A CONSEQUENCE OF <u>Intermittent CV Disease</u>									8 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
422.1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1966</u> , to <u>Dec, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE		22c. DATE SIGNED								
<u>J. Ralph Horky</u>		12/9/68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
J. Ralph Horky, M.D.		Churchville, Maryland 21028								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7 Dec. 1968		Bakers Cemetery		Aberdeen (Harford) Maryland				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
<u>Whitely McCowan Sr.</u>		Tarring Funeral Home				<u>J. H. Jones</u>				
Aberdeen, Md. 21001		DATE DEC 9 1968								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 17596 CERTIFICATE OF DEATH 17607 </div>									
1 DECEASED NAME (Type or print) First Middle Last <i>Amelia E. Bieri</i>			2a. DATE OF DEATH Month Day Year <i>December 4 68</i>			2b. HOUR <i>8:55 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>CAU</i>		5 DATE OF BIRTH <i>11 May 1894</i>		6 AGE (In years last birthday) <i>74</i> YRS.		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>Aberdeen Prov GR</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>U.S. Kirk Army Hosp.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Res dence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c CITY OR TOWN <i>Joppa</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>306 Chandler Court</i>	
14 FATHER'S NAME First Middle Last <i>Anthony Stratton</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Pauline Speidel</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>NO</i>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>188-16-1875</i>		17. INFORMANT Address <i>Mrs Raymond Roecker, 306 Chandler Ct, Joppa, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <i>4450</i> IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mangrove of feet</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Generalized Arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 Hrs.</i> <i>10 days</i> <i>Unknown.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <i>24 Nov</i> , 19 <i>68</i> , to <i>4 Dec</i> , 19 <i>68</i> , that (X) (we) last saw the deceased alive on <i>4 Dec</i> , 19 <i>68</i> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.									
22b SIGNATURE <i>Phillip Roberts</i>				22c. DATE SIGNED <i>5 Dec - 68</i>					
22d PHYSICIAN'S NAME (Type) <i>PHILLIP ROBERTS, MAJ, MC</i>				22e ADDRESS <i>US KIRK ARMY HOSP, ABERDEEN PR GR, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>6 Dec. 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Northwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Philadelphia, Penna</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17597					17608				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
Edward Blackson					12 12 68 8:15am				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS	
Male		white		11-15-97		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		USA				Harford		Hayre de Grace	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hayre de Grace		Citizens Nursing Home		Engineer		DORR			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Harford		Aberdeen				134 Edmund St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		16c. INFORMANT	
George W. Blackson		Luella Streaker				705-09-7362		Records, Citizen's Mng Home, Hbts. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of bladder</u>									
188X DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-10-1968, 1968, to 12-10-1968, that (I) (we) last saw the deceased alive on 12-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
Peter P. Rodman, M.D.		8 Law St., Aberdeen Md. 21001							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial Dec. 14/1968				Trinity Cemetery		Perryville Cecil, Md			
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
H. J. Johnson		DEC 31 1968		J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card index pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17598

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17609

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Lawrence		William	Brown, Jr.	Dec 17 1968		0155AM		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.N.
Male	Cau		18 May 1909		59 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
Penna.	USA			Harford				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Aberdeen		Proving Ground US Kirk Army Hospital		Supply		A.P.G.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Harford	Aberdeen		631 Calaine Drive			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Lawrence		William	Brown Sr.	Florence	MINERVA		Dace	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		1932-1961		Mrs. Martha Brown, 631 Calaine Dr, Aberdeen, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.								12 Hrs
IMMEDIATE CAUSE (a) Acute Myocardial Infarction								
4109 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								7 Years
(b) Arteriosclerotic Heart Disease								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from 16 Dec, 1968, to 17 Dec, 1968, that (I) (we) last saw the deceased alive on 17 Dec, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
PHILLIP ROBERTS, MAJ, MC								17 Dec 68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		12-20-1968		ARLINGTON NATIONAL CEM. FORT MYER		VA		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
K. Madison Mitchell, Harold Gace, Md.				DEC 23 1968				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2k, 2l, 2m, 2n, 2o, 2p, 2q, 2r, 2s, 2t, 2u, 2v, 2w, 2x, 2y, 2z, 3-21-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

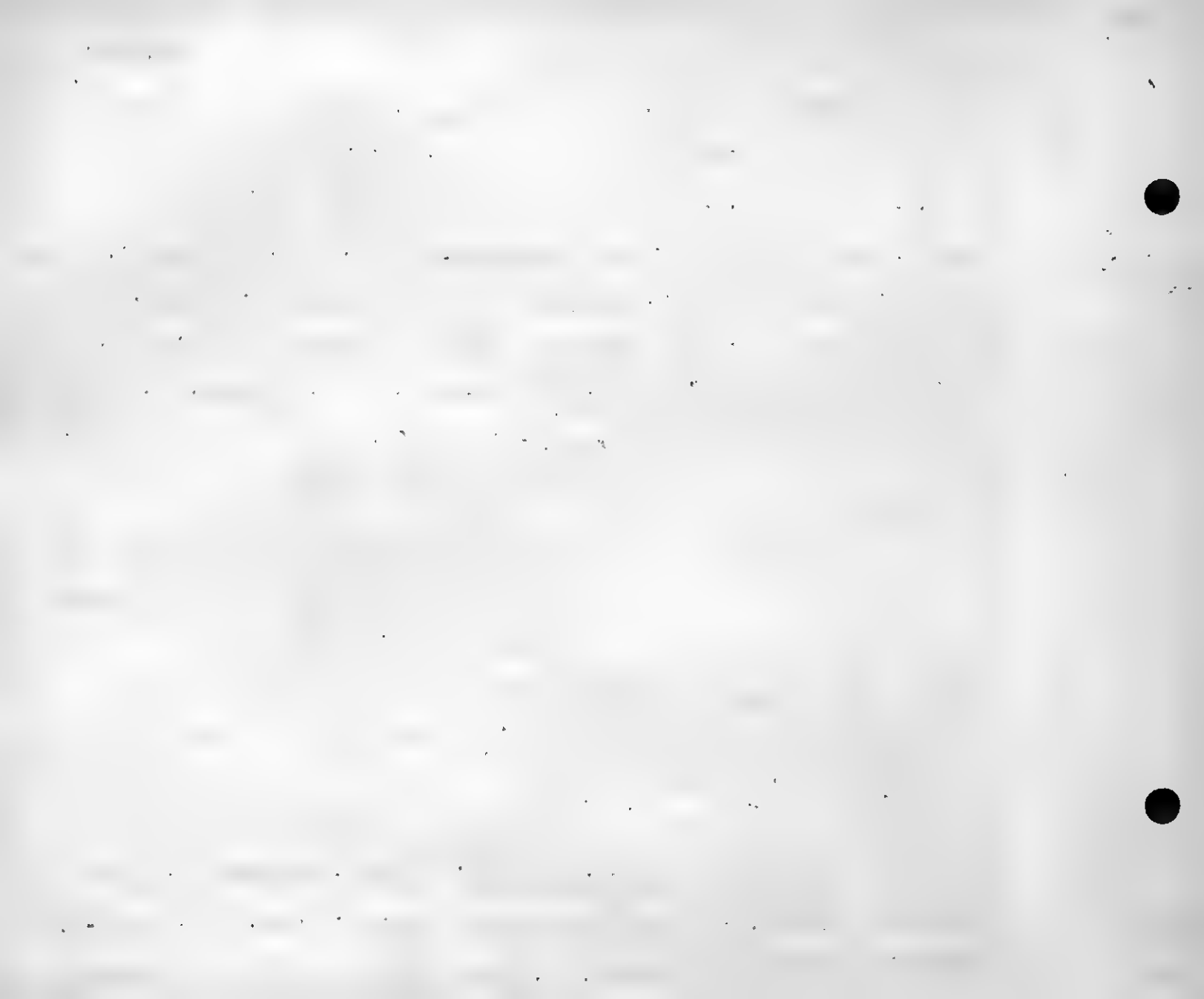
03921

1. DECEASED-NAME (Type or Print)		First ROBERT		Middle PAUL		Last BOWMAN		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> 12-5-1968		Month 12 Day 5 Year 1968		2b. HOUR 5:00 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 6/22/44		6 AGE (In years last birthday) 24 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD March Day 8 , Year 1969		2d. HOUR 5:00 PM	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.							
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pennington Funeral Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trucker-Selfemployed		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rte #2 Carsins Run					
14. FATHER'S NAME First Denwood		Middle N.		Last Bowman		15. MOTHER'S MAIDEN NAME First Rosalie		Middle Latka		Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give date of discharge) 1965--1967		16b. SOCIAL SECURITY NO 213-46-3157		17. INFORMANT ADDRESS Denwood N. Bowman, R.D. 2, Aberdeen, Md.							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Found in water, presumed drowned 8300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12-5-1968 P.M. 12-5-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Duck hunting in boat which capsized									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Chesapeake Bay		21f. LOCATION Street or R.F.D. No. City or Town County State Off Battery Island & Carpenter's Pt 3 ml. S. of Havre de Grace Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED March 9, 1969	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 11 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford Co.) Md.							
24. FUNERAL DIRECTOR Tarring Funeral Home., Aberdeen, Md. 21001		ADDRESS		25a. RECD BY REGISTRAR DATE 12 1969		25b. REGISTRAR'S SIGNATURE William J. Young							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			27. HOUR P M
HERBERT			S. BURNS, SR.			December 7 1968			7:10 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		25 December 1899		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
N.C.		U.S.A.				Harford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace			Harford Memorial Hospital			Radio Tower Operator			Dept. of Army
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		603 Beards Hill Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William P. Burns (D)			Mary Lavina Scott (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			220-22-0523		Catherine B. Burns, Aberdeen, Md. 21001				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr. 5 1/2 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> hot white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 1963, to 12-7-1968, that (I) (we) last saw the deceased alive on 12-7-1968, and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		22e. DATE SIGNED	
Peter P. Rodman, M.D.			8 Law Street, Aberdeen, Md. 21001			12-9-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10 Dec. 68		Wesleyan Chapel Cemetery		Aberdeen, (Harford) Maryland			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home			DEC 11 1968			J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17690

17611

1. PLACE OF DEATH a. COUNTY HARTFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Hartford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - White Hall		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Route #23		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - White Hall	
f. STREET ADDRESS State Route #23		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Chenoweth		4. DATE OF DEATH Month Day Year Dec 10 1968	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19 1889
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (County & State, or foreign country) Bethesda, Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown William Chenoweth	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 216-10-945		17. INFORMANT Address Wife - Mrs Rosalie Chenoweth - White Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure + 1 DUE TO Conditions, if any, which gave rise to immediate cause (b) acute myocardial infarction (c) arteriosclerotic cardiovascular disease DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4777 none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. none	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) White Hall, Md.
21. I certify that (I) (the hospital) attended the deceased from Jan 26 1968 to DEC 10 1968 , that (I) (we) last saw the deceased alive on SEP 8 1968 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James F. White, Jr.		22b. DATE SIGNED 12/10/68	
22c. PHYSICIAN'S NAME (Type) JAMES F. WHITE JR		22d. ADDRESS Jarrettsville, Hartford Co., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-13-1968	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		25. REC'D BY REGISTRAR DEC 16 1968	
26. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

176921

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17612

1. DECEASED NAME (Type or Print) Milton L. Christman			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12-28-68			2b. HOUR 5A		
3. SEX M	4. RACE C	5. DATE OF BIRTH May 17, 1952	6. AGE (In years last birthday) 16 YRS	IF UNDER 1 YEAR MONTHS 11 DAYS 10 HOURS 10 MIN	7c. DATE PRONOUNCED DEAD MONTH Dec DAY 28 YEAR 1968			2d. HOUR 5A
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH Harpard			10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hagerstown Memorial Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student			12b. KIND OF BUSINESS OR INDUSTRY High School			13a. STREET AND NUMBER 645 Hickory Circle		
13b. COUNTY Harpard			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Milton Middle L. Last Christman			15. MOTHER'S MAIDEN NAME First Alice Middle V. Last Giles			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b. SOCIAL SECURITY NO. 215-56-5076			17. INFORMANT Mr. Milton L. Christman			ADDRESS 645 Hickory Circle Aberdeen, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day Year 12-28-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State Aberdeen Harpard		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Gerald P. Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bohannon			22b. DATE SIGNED 12-29-68		
EXAMINER'S NAME (Type) Gerald P. Palmer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Aberdeen, Harpard, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 31, 1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		
23d. LOCATION (City or Town) (County) (State) Aberdeen, Harpard, Md.			24. FUNERAL DIRECTOR Charles J. Bullock			25a. REC'D BY REGISTRAR JAN 2 1969		
25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17622		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17613	
Item #6, Film 409 1/31/69 km							
1. DECEASED NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR	
First Middle Last Martha E. Christie			Month Day Year 12 2 68			11:15 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Female		American-N		5/1/?? <i>do not know yr.</i>		???	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Perryman, Md.		USA				Harford Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. OCCUPATION (Kind of work done during most of working life, even if retired.)	
Havre de Grace			Brevin Nursing Home			Waitress	
13a. SOCIAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Harford		Perryman		P.O. Box
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
First Middle Last Solomon E. Oiles			First Middle Last Amelia E. Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT			
no		705-09-9052		Mrs. Eva Simpson, Aberdeen Md. 2001			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>							<u>M.I.N.</u>
DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD</u>							<u>YEARS.</u>
DUE TO, OR AS A CONSEQUENCE OF <u>SYPHILIS</u>							<u>YEARS.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>AORTIC ANEURYSM</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
		Hour A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased and saw the deceased alive on <u>Dec 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE <u>Charles Judge</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>12-2-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>S. LEYTE-VIDAL, M.D.</u>				22e. ADDRESS <u>114 W. BEL AIR BLVD. ABERDEEN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>burial</u>		<u>12-1-1968</u>		<u>St. James C.M.E. Cemetery</u>		<u>Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>DEC 10 1968</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17603

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17614

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Grace			Lee	Currier	12 Month 13 Day 68 Year			3:50 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		12-29-1885		81 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Harford Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Citizens Nursing Home				Housewife		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Harford		Havre de Grace		YES		825 S. Market St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Wm. BENJAMIN CHESNEY						ALICE THOMPSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
			1499			JAMES A. CURRIER			2138		
			218-54-2113			Havre de Grace Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Decompensation										One week	
DUE TO, OR AS A CONSEQUENCE OF											
(b) A.S.C.V.D.										One year	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Cerebral Vascular Thrombosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1968, to Dec 13th 1968, that (I) (we) lost saw the deceased alive on Dec 13th 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED			
Edward C. Loo, M.D.								12/16/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Dec 16, 1968		Wesleyan Chapel Cn.		HARFORD Co.		MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles Judge		Havre de Grace, Md.		DATE DEC 18 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

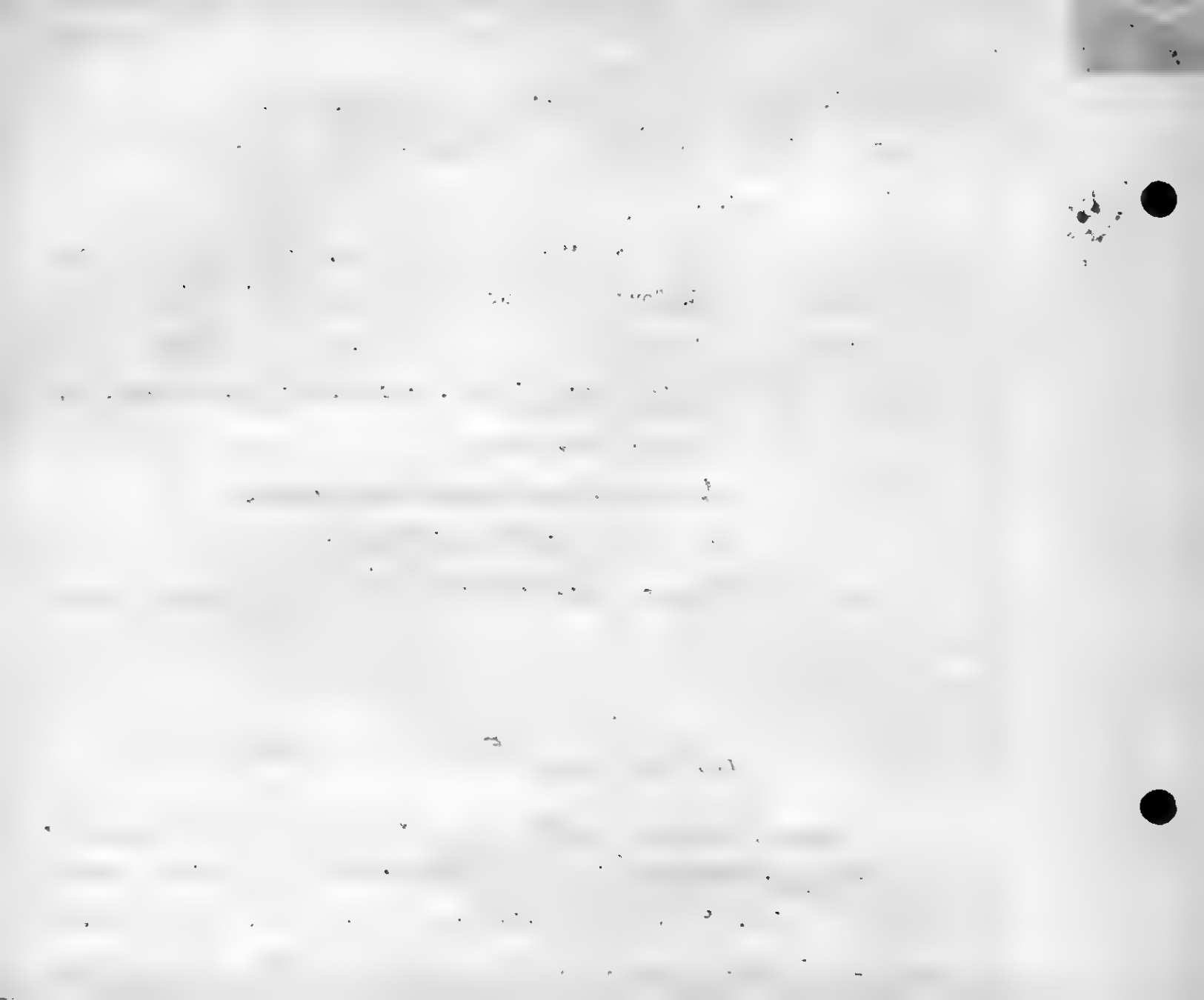
17604

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17615

1 DECEASED NAME (Type or print) ELIZABETH		First Middle Last DENNISON		2a. DATE OF DEATH Month December Day 24 Year 1968		2b. HOUR 12:30 PM	
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH 20 January 1868		6 AGE (In years last birthday) 100 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Perryman		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 112		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Perryman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Box 112		14. FATHER'S NAME First George Middle Webster Last (D)		15. MOTHER'S MAIDEN NAME First Eliza Middle Gibson Last (D)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-48-1258		17 INFORMANT Address Mary E. Collins, Box 112, Perryman, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Serulity - Gastroenteritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 66 , to 12/24 , 19 68 , that (I) (we) lost saw the deceased alive on 12/10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George T. Stansbury, M.D.		22c. DATE SIGNED 12/24/68		22d. PHYSICIAN'S NAME (Type) George T. Stansbury		22e. ADDRESS 509 Revolution St. Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 28 Jan. 68		23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Maryland	
24. FUNERAL DIRECTOR ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001				25a. RECD BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



17695

17616

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Benjamin			First Middle Last			2a. DATE OF DEATH Dec Month 8 Day 68 Year			2b. HOUR 1030M		
3. SEX M			4. RACE CAU			5. DATE OF BIRTH Oct. 14, 1906			6. AGE (in years last birthday) 62 YRS.		
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH Aberdeen Proving Ground			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 45K - K Army 1805K			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ENGINEER - SIG. MTD			12b. KIND OF BUSINESS OR INDUSTRY A.P.G.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVER DE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 641 North STOKES ST.			14. FATHER'S NAME First Middle Last BENJAMIN H. ELLIOTT			15. MOTHER'S MA DEN NAME First Middle Last DELLA SAMPSON			Address 641 STOKES ST. HAVER DE GRACE MD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-03-0998			17. INFORMANT MYRTLE L. ELLIOTT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation											
4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Philp Palmer						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 8 DEC - 1968		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12-11-1968			23c. NAME OF CEMETERY OR CREMATORY ROCK RUN CEM.			23d. LOCATION (City or Town) (County) (State) HARFORD MD.		
24. FUNERAL DIRECTOR R. Madison McNeil						ADDRESS HAVER DE GRACE MD			25a. REC'D BY REGISTRAR DEC 10 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Herbert Marshall			FAY			Dec. 12 1968			4:10 PM	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
male	white		Aug 19 - 1890			28 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Poland		U.S.A.				HARFORD Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HAURE de Grace		HARFORD Memorial Hosp. School						Nursing Engineer		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			HARFORD		Forest Hill		YES <input type="checkbox"/> NO <input type="checkbox"/>		205 MARSHALL Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Dean W. Fay			Laddie Hockenbury							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		24. Address			
No			517-05-9188		Mr. M. Fay		Van Buren St Ogden Utah			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
332x Diabetes Mellitus, Stage III										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> , 19 <u>68</u> , to <u>12-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
Dante U. Monakil, M.D.										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
DANTE U. MONAKIL, M.D.		211 N. Union Ave. Harford, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		12/16/68		Washington Mem. Hosp. Ogden Utah						
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Charles Judge		Harford, Md.		DATE DEC 16 1968		Charles Judge				



2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, enter in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

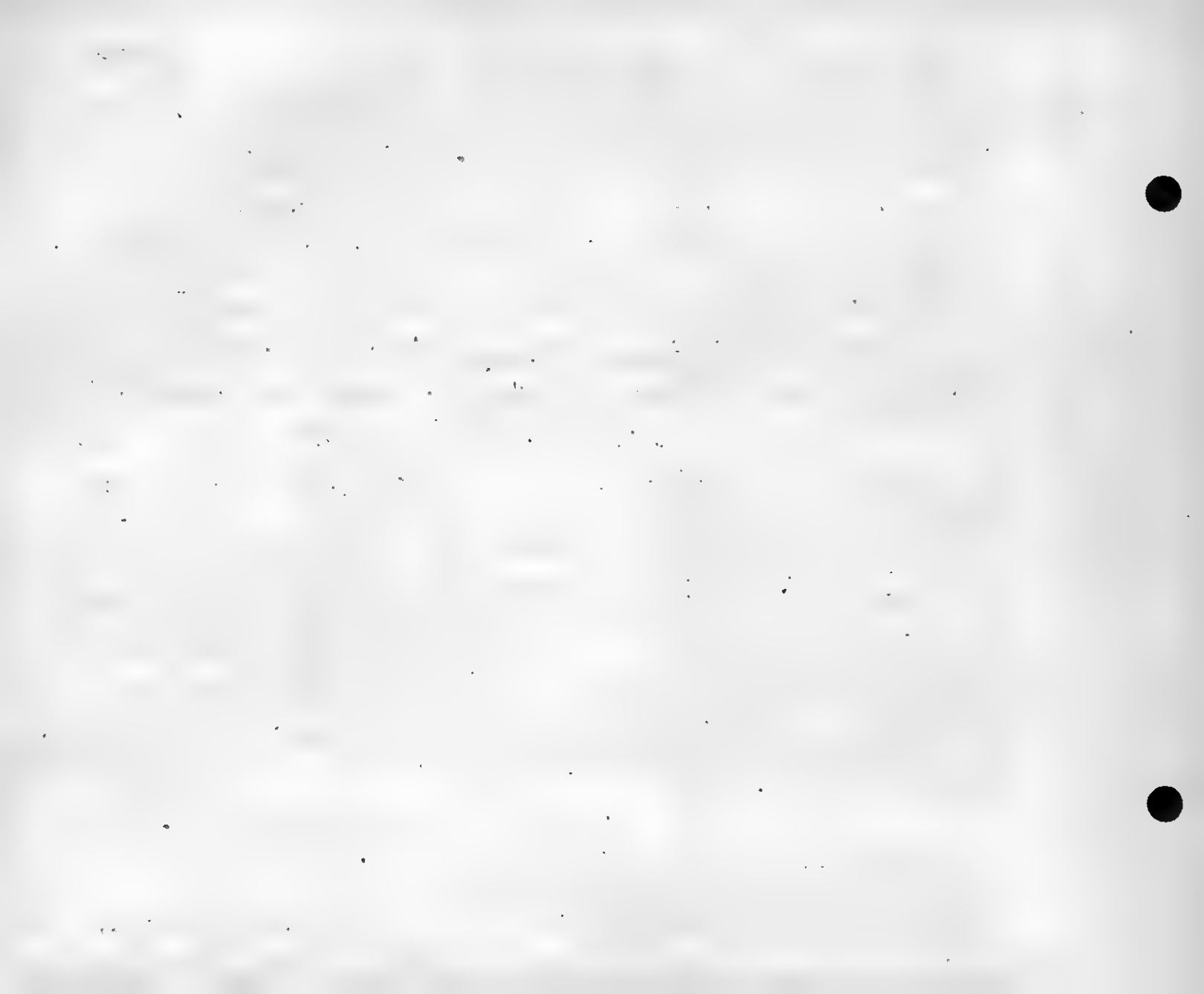
VR A15 (4)
30M REV. 1/68

17607		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17618	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH	
SARAH			GARLAND	FRANCIS	Dec	Month	13 Day Year 68
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)	
FEMALE		WHITE		February 6, 1903		65 YRS.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MASS.		USA		Harford		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hosp		Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md		Cecil		BAINBRIDGE		Quarters E.	
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME	
James			Ford			Sarah Campbell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT		
No			031-20-9979		Records, Harf. Mem. Hosp., Havre de Grace, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive metastasis</u>							
174X DUE TO, OR AS A CONSEQUENCE OF <u>Primary Cap of it breast</u>							20 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
170X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year P.M. ?9					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>68</u> , to <u>12-13</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE				DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED
<u>Henry H. Kwak</u>							<u>12-13-68</u>
22d PHYSICIAN'S NAME (Type)				22e ADDRESS			
HENRY H. KWAK				608 S. Union Ave, Havre de Grace			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		Dec. 16, 1968		Oak Hill Cemetery		Gloucester Essex Mass.	
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son, Perryville, Md.				DEC 30 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
Wilmer		Gross						December 22, 1968		5 P M	
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		January 21, 1890				78 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U. S. A.				Harford Md.					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Taylor		Jarrettsville Pike				Farmer			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Harford		Monkton				RD #1, Box 70			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
William B. Gross				Catherine R. Hope							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		RD #1 Address Box 70					
No		215-18-3071		Edith F. Gross		Monkton, Md. 21111					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										immediate	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4. <u>Diabetes mellitus, leukemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19		none							
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
none		none		none		none		none		none	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>60</u> , to <u>12/22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
James F. White, Jr.								12/23/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
James F. White, Jr.		Jarrettsville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		12/26/1968		Bethel		Madonna, Harford,				Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles E. Kurtz Jarrettsville, Md.				DEC 26 1968		J Charles Judge					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17620

17620

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR
Earl Lester Hagelgans					<input type="checkbox"/> MATED	12	10	1968	M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years not birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	12c DATE PRONOUNCED DEAD
M	W	4/14/1900	68 YRS	<input checked="" type="checkbox"/> NEVER MARRIED					Month
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		10c DATE PRONOUNCED DEAD	
Bradford Pa		U.S.A.		WIDOWED		Harford		Month	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13d HOUR	
Havre de Grace		1204 Howard Memorial Hospital		Havre de Grace				1968	
13a USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS		13e STREET AND NUMBER	
Md		Cecil		Crownsville		YES		NO	
14 FATHER'S NAME		15 MOTHER'S M maiden name		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT	
John Hagelgans		Winie Kinsinger		No		4107		Mrs C. Johnson, 845 College Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4107						YES		NO	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO	
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F. No		City or Town		County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b DATE SIGNED		23a LOCATION (City or Town)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
ACTUAL SIGNATURE Gerald E Palmer		12-11-68		Baltimore		12/13/68		St. Mary's	
EXAMINER'S NAME (Type)		24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		26. DATE	
Gerald E Palmer		James H. Houch		DEC 13 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by a funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <i>Edna May Hall</i>			2a DATE OF DEATH Month <i>December</i> Day <i>24</i> Year <i>1968</i>			2b HOUR <i>4:30</i> AM				
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Sept. 7, 1886</i>		6 AGE (in years last birthday) <i>82</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Hartford</i>				
10 CITY OR TOWN OF DEATH <i>Hartford</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Mem. Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		
13a USJA. RESIDENCE (Where deceased lived, if not in hospital admission) STATE <i>Md</i>			13b COUNTY <i>Hartford</i>		13c CITY OR TOWN <i>Bel Air</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>233 Hickory Ave</i>	
14 FATHER'S NAME First <i>George</i> Middle <i>-</i> Last <i>Reigle</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>-</i> Last <i>Russell</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <i>154-12-8463D</i>		17 INFORMANT (Daughter) <i>838-6866</i> <i>Mrs. Lyda M. Hill</i>		Address <i>233 Hickory Avenue</i> <i>Bel Air, Maryland 21014</i>			
18 CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Infectious Mononucleosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Blunt Asphyxia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>170X</i>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <i>12-19, 1968</i> , to <i>12-24, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-24, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>William K. Beendle</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <i>12/24/68</i>										
22d PHYSICIAN'S NAME (Type) <i>William K. Beendle</i>			22e ADDRESS <i>W. Broad St. Williams St. Bel Air, Maryland 21014</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Dec. 27, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Tews Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Clyde, Sandusky Co., Ohio</i>			
24 FUNERAL DIRECTOR <i>Joseph William Foster</i>				25a REC'D BY REGISTRAR <i>DEC 26 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17622	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) Darrell Joseph Hamn			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED 12-14-68			2b HOUR M		
3 SEX M		4 RACE W		5 DATE OF BIRTH		6 AGE (in years last birthday) 27 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) N.C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford		
10 CITY OR TOWN OF DEATH Haure de Grace			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Doa Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b KIND OF BUSINESS OR INDUSTRY Farmer		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.C. COUNTY ...				13c CITY OR TOWN ...		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Rock Hill Rd.			
14 FATHER'S NAME First Middle Last Walter Hamn			15 MOTHER'S M maiden name First Middle Last Hazel Arnold			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO. ...		
17 INFORMANT Howard Hamn			ADDRESS West Lane Pa			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull DUE TO, OR AS A CONSEQUENCE OF (b) Crushing Injury Chest DUE TO, OR AS A CONSEQUENCE OF (c) ...			APPROXIMATE INTERVAL BETWEEN ONSET AND D.A.T.H.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8251											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 7:30 PM 12-14-68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Accident					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Inter Exchange			21f LOCATION Street or RFD No City or Town County State JFH Highway Cecil Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 12-15-68					
EXAMINER'S NAME (Type) Gerald C Palmer MD			ADDRESS (Street, city, town, or county) ...			23a BURLIAL, CREMATION, REMOVAL (Specify) removal			23b DATE Dec. 15, 1968		
23c NAME OF CEMETERY OR CREMATORY Jefferson, Cecil Co. N.C.			23d LOCATION (City or Town) (County) (State) ...			24 FUNERAL DIRECTOR RALPH M REED			ADDRESS RISING SUN, MD		
25a REC'D BY REGISTRAR DEC 17 1968			25b REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17612

17623

1. DECEASED-NAME (Type or print) Bertie Edith Harden			2a. DATE OF DEATH Month December Day 13 Year 1968			2b. HOUR 4 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 8, 1911		6. AGE (in years lost birthday) 57 YRS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Box 382 F Angleside Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electronic Tech.		12b. KIND OF BUSINESS OR INDUSTRY Space Work	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First John Middle H.. Last Effler			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Shehan Last Shehan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 238-03-0478		17. INFORMANT Mr. Charles E. Harden		Address Fallston, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF, (b) Metastatic Carcinoma from Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-1- , 19 68 , to 12-13- , 19 68 , that (I) (we) last saw the deceased alive on 12-13- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kermit P. Bonovich M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-14-68	
22d. PHYSICIAN'S NAME (Type) Kermit P. Bonovich M.D.				22e. ADDRESS 1916 Bel Air Rd. Fallston, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Overlea Baltimore, Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son				ADDRESS Abingdon, Maryland		25a. REC'D BY REGISTRAR DEC 17 1968	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) ETTA			First M.			Middle HARKINS			Last Dec			2a. DATE OF DEATH (17) 17	2b. HOUR 1:30
3. SEX Female			4. RACE White			5. DATE OF BIRTH March 26, 1877			6. AGE (In years last birthday) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD			Md	
10. CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY HARFORD			13c. CITY OR TOWN FALLSTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER (RFD#, Box#15) Old Fallston Road	
14. FATHER'S NAME First John H			Middle Barrow			Last Margaret			15. MOTHER'S MAIDEN NAME First Stump				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. 218-18-7108			17. INFORMANT (Daughter) 817-0876 Mrs. Mildred H. DEETS			Address 25541 Box #15 Fallston, Maryland 21047				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis													
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Cerebrovascular													
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia - bilateral													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 68 , to 12-17 , 19 68 , that (I) (we) last saw the deceased alive on 12-17 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dante U. Monakic, M.D.			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/17/68				
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIC, M.D.			22e. ADDRESS 21 N. Union Ave. Harford Co. Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 19, 1968			23c. NAME OF CEMETERY OR CREMATORY DEER CREEK Methodist Ch. Cem.			23d. LOCATION (City or Town) (County) (State) Forest Hill, Harford Co., Maryland 21050				
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR DEC 20 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				



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VR A15 (4)
MSM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17614

17625

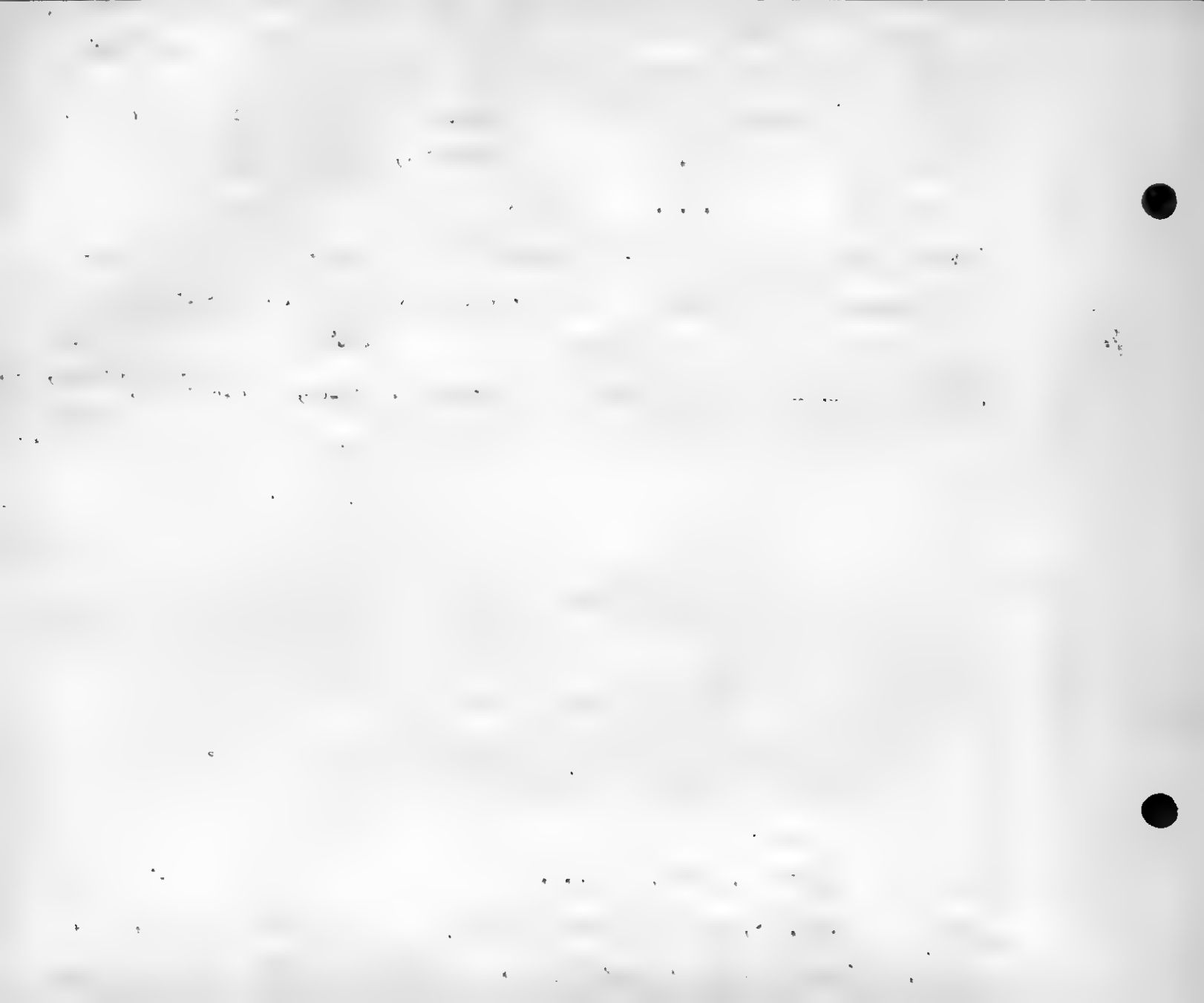
1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Whiteford		c. LENGTH OF STAY IN 1b 18 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Susquehanna Hall Road		e. STREET ADDRESS Susquehanna Hall Road	
3 NAME OF DECEASED (Type or print) LAURA HARPER		4 DATE OF DEATH Month December Day 22 Year 1968	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 19, 1894
9 AGE (In years birth day) yrs 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Warsaw, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Helms		14. MOTHER'S MAIDEN NAME Margaret Howard	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 135-28-7319	
17 INFORMANT Joseph M. Harper, Whiteford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 1951 IMMEDIATE CAUSE (a) General Carcinomatosis DUE TO (b) Pelvic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1992 None		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from July 1965 to Dec 22, 1968 , that (I) (we) last saw the deceased alive on Dec 19, 1968 , and that death occurred at 3 AM , from causes and on the date stated above			
22a SIGNATURE Joseph M. Harper		22b DATE SIGNED Dec. 23, 1968	
22c. PHYSICIAN'S NAME (Type) Joseph A. Hunt, M.D.		22d ADDRESS Delta, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 24, 1968	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or town) (County) (State) Alexandria, Virginia
24 FUNERAL DIRECTOR JOHN H. HARKINS		25a REC'D BY REGISTRAR DEC 27 1968	
ADDRESS Delta, Penna.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR		
Florence Jones Hobbs						Dec 26 1968		10:25 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		
Female		Cau.		October 1, 1886		82 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Harford				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Citizen Nursing Home			House Wife				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			13b COUNTY Cecil		Port Deposit		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		S. Main Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
George Jones			Martha Hall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No			Unknown		Florence L. Gibson, 73 N. Main St., Port Deposit, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma Transverse Colon - Left</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Intestines</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Intestines</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug - 24, 1968</u> , to <u>Dec 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 26 - 1968</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Clarence I. Benson</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Dec. 27-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>					22e. ADDRESS <u>Port Deposit Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>Dec. 29, 1968</u>		<u>Hopewell Cemetery</u>		<u>Port Deposit Cecil, Md.</u>				
24 FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13

17616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17627

1 DECEASED NAME (Type or print) George R Hopkins			2a. DATE OF DEATH Month 12 Day 22 Year 68			2b. HOUR 3:23 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 28 July 1881		6 AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH HARFORD Md	
10 CITY OR TOWN OF DEATH Harre-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer Ret.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R.D.#1 Box 288		14. FATHER'S NAME First John Middle Edward Last Hopkins (D)		15. MOTHER'S MAIDEN NAME First Rachel Middle L. Last Hopkins (D)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 213-18-1060-A		17 INFORMANT Howard Thomson Jr.		Address Laurel Springs, N.J.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe pulm edema & Congestive DUE TO, OR AS A CONSEQUENCE OF Cardiac failure due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized a.s. CVD DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 22, 1968 , to Dec 22, 1968 , that (I) (we) last saw the deceased alive on Dec 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry H. Kwan DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED Dec 22-68			
22d. PHYSICIAN'S NAME (Type) HENRY H. KWAN				22e. ADDRESS 608 S. Union Ave. Harre-de-Grace			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 24 Dec. 68		23c. NAME OF CEMETERY OR CREMATORY Rock Run Cemetery		23d. LOCATION (City or Town) (County) (State) Havre de Grace, Maryland	
24 FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) Benjamin Monroe Johnson					2a DATE OF DEATH Month 12 Day 24 Year 1968			2b HOUR 8 P M	
3 SEX Male		4 RACE C		5 DATE OF BIRTH April 20, 1911			6 AGE (In years last birthday) 57 YRS		7 UNDER 1 YR MONTHS 8 DAYS 4
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford Md			
10 CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Warehouse			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) R.P.H.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Resident before admision) STATE Md			13b COUNTY Harford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY, LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e STREET AND NUMBER P.O. Box 193
14 FATHER'S NAME First Middle Last No Record					15 MOTHER'S MAIDEN NAME First Middle Last Helen Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? Yes			16b. SOCIAL SECURITY NO. W.W.H. 217-09-1500		17 INFORMANT Margaret Pearl Johnson Aberdeen, Md Address P.O. Box 193				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardiovascular Disease									
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cerebral Vascular Disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION 4-20		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that (I) (this hospital) attended the deceased from 12-15, 1968 to 12-24, 1968, that (I) (we) attended the deceased since on 12/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE George T. Stansbury, M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 12/25/68		
22d PHYSICIAN'S NAME (Type) George T. Stansbury, M.D.					22e ADDRESS 569 Revolution St. Havre de Grace, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/28/68		23c NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery		23d LOCATION (City or Town) (County) (State) Aberdeen Harford Md			
24 FUNERAL DIRECTOR Elmer E. Budorck					ADDRESS Havre de Grace, Md		25a REC'D BY REGISTRAR DATE JAN 2 1969		25b REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Blanche Kinnier					2a. DATE OF DEATH Month Dec Day 27 Year 68		2b. HOUR 1:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/29/1876		6. AGE (In years last birthday) 92 YRS.		7. UNDER 1 YEAR MONTHS 1 DAYS 15 HOURS 15 MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH HAURE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) And wife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USLA. RESIDENCE (Where deceased lived, if institution on residence before admission) STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE DE GRACE		13d. INSIDE CITY, WITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 515 Giles	
14. FATHER'S NAME First Saloman Middle Thomas M. Last Tchell			15. MOTHER'S MAIDEN NAME First ANNA Middle Virginia Last EVANS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO ---		17. INFORMANT Mrs John D. Duke		18. ADDRESS 515 Giles St. Haure de Grace, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 400 X (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) ---									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Dehydration + A.S.C.V.D. + Senility									
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. --- Month --- Day 19 P.M. ---		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) ---					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC) ---		21f. LOCATION Street or R.F.D. No --- City or Town --- County --- State ---					
22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 68 , to 12/27 , 19 68 that (I) (we) last saw the deceased alive on 12/27 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Edward C. Loo				DEGREE ---		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, MD				22c. DATE SIGNED 12/27/68					
23a. BURIAL, CREMATION, OR OTHER Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION (City or Town) Haure de Grace		23e. (County) HARFORD	
24. FUNERAL DIRECTOR ---				ADDRESS ---		25a. REC'D BY REG. STRAR ---		25b. REG. STRAR'S SIGNATURE Charles Judge	
				DATE DEC 31 1968					



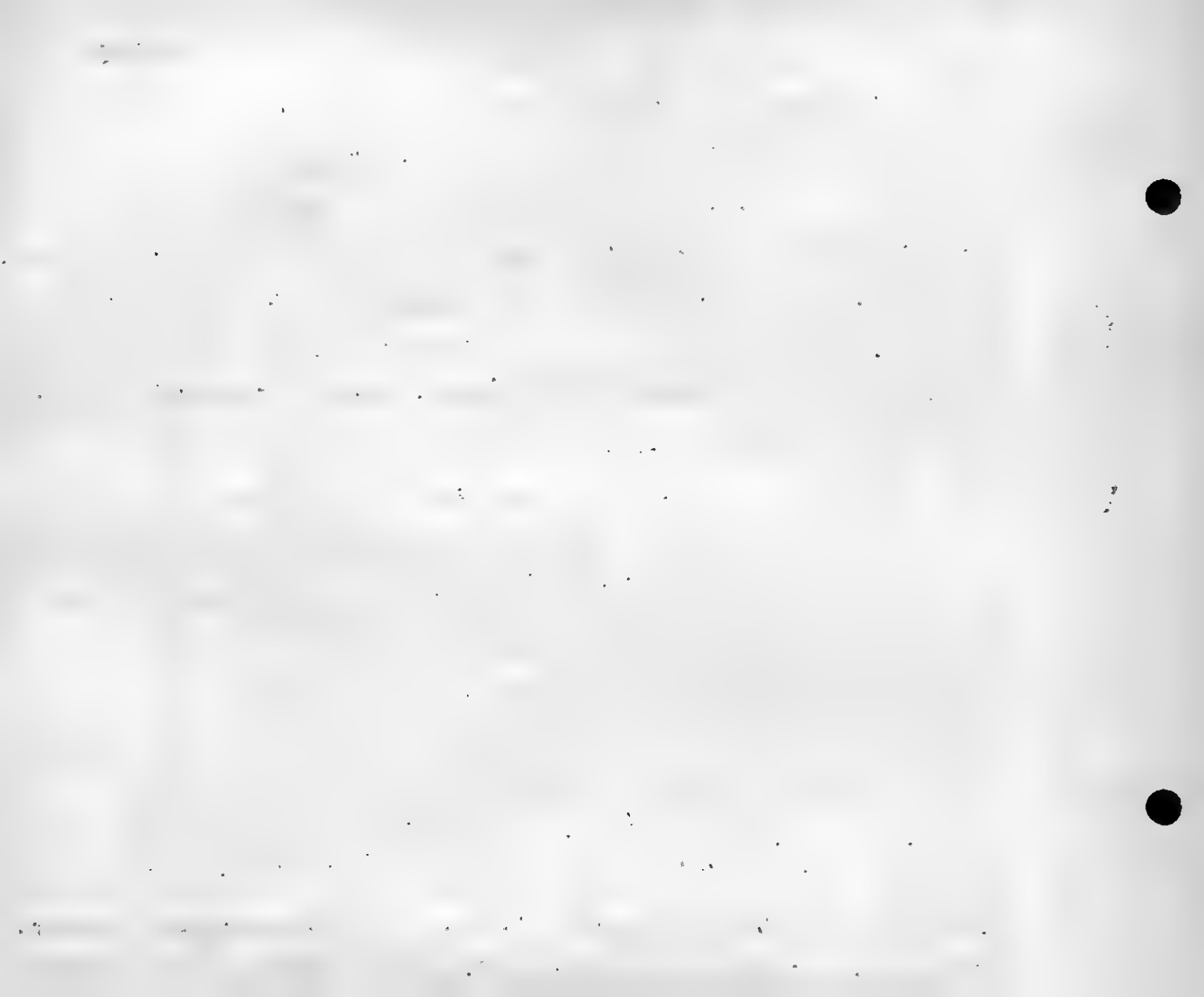
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17620		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17631	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Clifton			Wilson		Lewis	December, 15, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)	
Male		Colored		Feb. 28, 1900		68 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Harford Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Jarrettsville		Nelson Mill Road		Laborer		Floor finishing	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Harford		Jarrettsville		Nelson Mill Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
John			Lewis			Rosetta Douglas	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address	
No		---		Mrs. Myrtle T. Lewis		Jarrettsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							1 1/2 hr.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>							4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Pulmonary Fibrosis Emphysema</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>15 Dec</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>16 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Edwin W Whiteford MD</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>15 Dec 68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Edwin W Whiteford MD</u>		22e. ADDRESS <u>Whiteford, Md. 21164</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/18/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St James A.M.E.</u>		23d. LOCATION (City or Town) (County) (State) <u>Federal Hill, Harford, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17632											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17632											
Item 1 Film 408 1/2/69 kk						CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH					
First Middle Last						Month Day Year					
EDWARD Edgar C						Dec 24 68					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
male		Cauc		7 May 1899		68 69 yrs.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wisc		USA				Larford Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Aberdeen				US Kirk Army Hosp				Dealer Trainer			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 1ST YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Oregon				Clatsop		Seaside		YES <input type="checkbox"/> NO <input type="checkbox"/>		2100 S Franklin	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Arthur Lindsey				Louella Barnes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes				531 03 7568		Orville L. Tobiason, Strs 4, APC, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Pulmonary Edema										1 hour	
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction										11 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4-10-68 DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes Mellitus, Hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
N/A		I/A									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		19		N/A							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
		N/A		N/A							
22a. I certify that (I) (this hospital) attended the deceased from 0030 24 Dec 19 68, to 4100 24 Dec 19 68, that (I) (we) last saw the deceased alive on 1100 24 Dec 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE PHILLIP L. FORTNITS, M.D., AJOH, M.C.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 24 Dec 68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS US Kirk Army Hospital, APC, Md.					
23a. BURIAL, CREMATION, or other disposition		23b. DATE 30 Dec. 68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory				23d. LOCATION (City or Town) (County) (State)			
								Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home, Aberdeen, Maryland						DATE DEC 30 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
CHARLES						May hew		Dec. 9 1968		12:10
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE	white		June 21, 1900		68 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Johnstown, Pa.		U.S.A.				HARFORD		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
HAURE de Grace		HARFORD Memorial Hosp		Carpenter						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		HARFORD		Pylesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD1-Box 219		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First
Edward						May hew		Anna		Rhaff
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
No		106-09-497		Theodore R. Mayhew		RD1, Box 219 Pylesville				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Melastatic Carcinoma										6 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of Rt. Kidney										> 3 months
DUE TO, OR AS A CONSEQUENCE OF (c) —										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
180x										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1968, to 12/9, 1968, that (I) (we) lost saw the deceased alive on Dec. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
Edward E. Loo, M.D.						12/9/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. LOCATION (City or Town)		(County)		(State)		
Edward E. Loo, M.D.		Harford de Grace, Md.		Pylesville		Harford Co.		Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		Dec 12, 1968		St. Mary's Cemetery		Pylesville		Harford Co.		Md.
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John H. Harkins		Delta, Pa.		DATE DEC 12 1968		Charles Judge				



3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17633		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17634	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
William Jackson McCellan						Month	Day
						Year	2b. HOUR
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)
Male			White		April 8, 1887		81 YRS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
N.Y.			U.S.A.				Harford Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Havre-de-Grace			Harford Memorial Hospital		Firefighter (Ret.)		N.Y. City
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. AS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Md			Harford		Havre-de-Grace		103 Dever ST
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Jackson					McCellan	First	Middle
						Virginia	Hall
16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		
No			212-26-9753		George E. McCellan (Son)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebro Vascular Accident							
4367 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
331X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
		HOUR A.M. Month Day Year					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-7, 1968, to 12-7, 1968, that (I) (we) last saw the deceased alive on 12-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
[Signature]				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		12-8-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Gunther D. Hirsch, M.D.				Havre de Grace, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		11 Dec. 68		Grove Presbyterian Cemetery, Aberdeen, Maryland			
24. FUNERAL DIRECTOR				25a. BY REGISTRATION		25b. REGISTRAR'S SIGNATURE	
Robert Macomber Jr. Tarring Funeral Home				Aberdeen, Md. 21001		DEC 11 1968 [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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17624

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17635

1. DECEASED NAME (Type or Print) <i>Margaret E. McCOY</i>		First <i>E. McCOY</i> Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Dec</i> Day <i>6</i> Year <i>1968</i> HOUR <i>10:50</i> AM <input type="checkbox"/> PM	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>May 20 1884</i>	6. AGE (In years last birthday) <i>84</i> YRS	7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8. IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		7b. CITIZENSHIP (What country) <i>U.S.A.</i>		9. COUNTY OF DEATH <i>Harford</i>	
10. CITY OR TOWN OF DEATH <i>Adrian, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life) <i>Homemaker</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution) STATE <i>M.D.</i> COUNTY <i>Cecil</i>		13b. CITY OR TOWN <i>Port Deposit</i>		13c. STREET AND NUMBER <i>Rd</i>	
14. FATHER'S NAME First <i>Tennis</i> Middle <i>Tester</i> Last <i>Forester</i>		15. MOTHER'S MAIDEN NAME First <i>Lorette</i> Middle <i>Forester</i> Last <i>Forester</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-52248651</i>		17. INFORMANT <i>Ulysses E. McCoy</i> ADDRESS <i>Port Deposit</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fracture Femur</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>DUE TO, OR AS A CONSEQUENCE OF</i>					
(c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>904C</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year <i>11-19-68</i> HOUR A.M. <i>P.M.</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>Port Deposit</i> City or Town <i>Cecil</i> County <i>Md.</i> State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gerold E. Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>12-6-68</i>	
EXAMINER'S NAME (Type) <i>Gerold E. Palmer</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/9/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dopewell Cem.</i>	
24. FUNERAL DIRECTOR <i>Lee & Cateran</i>		23d. LOCATION (City or Town) <i>Port Deposit</i> County <i>Cecil</i> State <i>Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 12 1968</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17636

1 DECEASED-NAME (Type or Print)		First VINCENT		Middle BERNARD		Last MULLIN		7a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> Dec 8 19 68		2b HOUR 4 25 PM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH March 18, 1894		6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 19 68		2d HOUR 4 25 PM	
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md						
10. CITY OR TOWN OF DEATH Havre de Grace				11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp tal give street address) Harford Memorial Hospital				12a USUAL OCCUPATION (If not done before death) Salesman				12b KIND OF BUSINESS OR INDUSTRY Cars
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Harford		13c CITY OR TOWN Aberdeen,		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Moyer Drive		
14 FATHER'S NAME First Middle Last Bernard Mullin (D)				15 MOTHER'S MAIDEN NAME First Middle Last Lizzie Laubach (D)								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO (If yes give war or dates of service) 215-24-0339		17 INFORMANT Mrs. Richard Griffin, Aberdeen, Maryland						
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlus, on</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office build'ng, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 12-9-68						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10 Dec. 68		23c NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d LOCATION (City or Town) Aberdeen,		(County) Harford,		(State) Maryland		
24. FUNERAL DIRECTOR <u>Whitely W. Conner Sr.</u>				25a REC'D BY REGISTRAR DATE DEC 11 1968		25b REGISTRAR'S SIGNATURE <u>William J. Judge</u>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See also Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17637										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17637																																							
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR																																							
Sara Catherine Murphy										Month 12 Day 6 Year 68										10:30 PM																																							
3 SEX Female										4 RACE White										5 DATE OF BIRTH Aug. 13, 1900										6 AGE (In years last birthday) 68 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) 977d										7b CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Hartford Md.																													
10 CITY OR TOWN OF DEATH Havre de Grace										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hartford Memorial										12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) GIFT SHOP										12b KIND OF BUSINESS OR INDUSTRY STORE																													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md										13b COUNTY Hartford										13c CITY OR TOWN Havre de Grace										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 707 Giles St.																			
14 FATHER'S NAME First Middle Last Jerry T. Gilbert										15 MOTHER'S MAIDEN NAME First Middle Last Irene Adams										16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b SOCIAL SECURITY NO 216-12-0661										17 INFORMANT WILLIAM P. MURPHY										Address 707 GILES ST. HAVRE DE GRACE MD.									
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
IMMEDIATE CAUSE (a) 174X										DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic spread to the cranium																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Breast										6 yrs.																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										170X																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 11-17, 1968 to Dec 6, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										22b SIGNATURE Dante U. Monakil MD										22c DATE SIGNED 12-6-68																																							
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.										22e ADDRESS 211 N. Union Ave. Havre de Grace, Md.										22f. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>																																							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE DEC. 9, 1968										23c NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.										23d LOCATION (City or town) (County) (State) HAVRE DE GRACE, HARTFORD, MD.																													
24. FUNERAL DIRECTOR X Madison Mitchell										ADDRESS HAVRE DE GRACE MD.										25a REC'D BY REGISTRAR DATE DEC 10 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Howard Carl Mutschler						2a. DATE OF DEATH Month Day Year December 21 1968			2b. HOUR 3 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 19 1931		6. AGE (In years last birthday) 37 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Del. USA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY Unemployed		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 456		
14. FATHER'S NAME First Middle Last William F. Mutschler						15. MOTHER'S MAIDEN NAME First Middle Last Selma Schaefer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give date and nature of service) WW II				16b. SOCIAL SECURITY NO. 322 053 936		17. INFORMANT Name Address Mrs. Dorothy T. Mutschler					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>											
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4321 <u>Pulmonary Emphysema</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 12-21, 1968, to 12-21, 1968, that (I) (we) last saw the deceased alive on 12-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Dante U. Monakil MD						DEGREE PHYS		ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-21-68	
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.						22e. ADDRESS 211 N. Union Ave. Havre de Grace					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/31/68		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION (City or Town) Perryville		County Cecil		State Md.	
24. FUNERAL DIRECTOR Lee G. Johnson						ADDRESS Perryville		25a. FILED BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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17628

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17639

1 DECEASED NAME (Type or Print) HARRY EMERSON PALMER			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12-29 19 68			2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH May 31, 1913	6 AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS 	IF UNDER 24 HRS DAYS 	IF UNDER 24 HRS HOURS
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH HARFORD
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper		12b KIND OF BUSINESS OR INDUSTRY Oil Company
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Harford		13c CITY OR TOWN Havre de Grace		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Harry		Middle W.		Last Palmer (D)		15 MOTHER'S MAIDEN NAME First Lillian
Middle G.		Last Hopkins (D)		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b SOCIAL SECURITY NO 220-01-2934		17 INFORMANT Helen L. Palmer, Havre de Grace, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 4127 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED December 30, 1968		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
		ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2 Jan. 69		23c NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cemetery		23d LOCATION (City or Town) (County) (State) Aberdeen (Harford) Maryland
24 FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		ADDRESS		25a REC'D BY REG STRAR DATE JAN 2 1969		25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 415
30M REV

17639

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17640

1. DECEASED-NAME (Type or print) JENNIE		First JENNIE Middle H. Last PARKS		2a. DATE OF DEATH Month December Day 9 Year 1968		2b. HOUR 10 A MIN 25	
3 SEX Female		4. RACE W		5. DATE OF BIRTH March 25, 1891		6. AGE (in years last birthday) 77 YRS. MONTHS 11 DAYS 10 HRS. 25 MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Owen Middle Melvin Last Hall		15. MOTHER'S MAIDEN NAME First Rozie Middle Jane Last Parks		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO 212-50-4219		17. INFORMANT Address Edgewood, Md. Mrs. Lora L. Bizich, 2025 Armstrong St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 41 1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 68 , to 12-9 , 19 68 , that (I) (we) last saw the deceased alive on 12-9-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante U. Monakil, M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec. 9, 1968	
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.		22e. ADDRESS 211 N. Union Ave. Harford					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17630

CERTIFICATE OF DEATH

17641

1. DECEASED-NAME (Type or print) HOWARD			First Middle Last Watters PATTON Jr.			2a. DATE OF DEATH Month Day Year December 20 1968			2b. HOUR P 2:00 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 13, 1904			6. AGE (In years last birthday) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			Md.			
10. CITY OR TOWN OF DEATH Mr. Jarrettsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baldwin Mill Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerical			12b. KIND OF BUSINESS OR INDUSTRY State Road			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 89 Baldwin Mill Road			
14. FATHER'S NAME Howard Watters Patton			First Middle Last			15. MOTHER'S MAIDEN NAME Lillian May Gilbert			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 219-16-8012			17. INFORMANT Mrs. Harriet E. Crouse			Address Box 89 Baldwin Mill Rd. Forest Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100 (b) Chr. Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus (severe) 28 yrs.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Oct. 19, 1961 , to Dec. 20, 1968 , that (I) (we) last saw the deceased alive on Dec. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Willard P. Hudson M.D.						22c. DATE SIGNED Dec. 20, 1968						
22d. PHYSICIAN'S NAME (Type) Willard P. Hudson						22e. ADDRESS 1323 Rock Spring Rd. Forest Hill, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/23/1968		23c. NAME OF CEMETERY OR CREMATORY William Watters Mem.		23d. LOCATION (City or Town) (County) (State) Coopstown, Harford, Md.						
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.						25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Harold Hoover Pierce						2a. DATE OF DEATH Month December Day 2 Year 1968			2b. HOUR 4:30 MIN 15		
3 SEX Male		4. RACE White		5. DATE OF BIRTH October 30, 1928		6 AGE (in years last birthday) 40 YRS		F UNDER 1 YEAR MONTHS 1 DAYS 15		F UNDER 24 HRS. HOURS 4 MIN 15	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford Co., Md					
10 CITY OR TOWN OF DEATH HAVER DE GRACE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hartford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LINEMAN		12b. KIND OF BUSINESS OR INDUSTRY Telephone					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Hartford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 105 Crescent Dr.			
14 FATHER'S NAME First Robert Middle LEE Last PIERCE				15. MOTHER'S MAIDEN NAME First Emma Middle Clyde Last Cox							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		(If yes give war or dates of service) Dec 50 to Dec 52		16b. SOCIAL SECURITY NO. 213-28-3071		17 INFORMANT Wife 838-5794		Address 105 Crescent Drive Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Peritonitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pancreatitis										4 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Duodenal Ulcer disease										5 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5'11"											
19a. DATE OF OPERATION 11/27/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal ulcer				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 1968, to 12-2 , 1968, that (I) (we) last saw the deceased alive on 12-2 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles J. Foley Jr. M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec. 3, 1968			
22d. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR M.D.						22e. ADDRESS HAVER DE GRACE, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEC. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Hartford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway Williams St Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Charlotte			May		Potter		Dec		29 1968	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		2b HOUR	
Female		Caucasion		Oct 10, 1888			80 YRS		0130 M	
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Philadelphia			USA				Harford		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Aberdeen			Kirk US Army Hospital			House wife		Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Pennsylvania			Montgomery		Norristown				2009 Byrd Drive	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
George Chambers					Charlatt May Chambers (Haas)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No			206-42-3066		Daughter		Elinor Miller Qtrs 102 APG, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) CARDIAC ARREST										2 Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201										
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Carcinoma of Left (L) Breast										
19a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Oct 1968			Carcinoma of Left Breast							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (did not) attended the deceased from 2330 28 Dec 1968 , to 0130 29 Dec 1968 , that (I) (did not) last saw the deceased alive on 0130 29 Dec 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Clarence A. Martin MD									29 Dec 1968	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
MARTIN, CLARENCE A.					US KIRK ARMY HOSPITAL APG MD. 21005					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Rem. Burial		1/3/1968		West Laurel			Balu Cynwyd, Montgomery Co			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
H.W. Jenkins & Sons Co.			4905 York Rd. Balto. 12, Md.			JAN 2 1969		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17623

17644

1 DECEASED NAME (Type or print) First Middle Last DAVID Ellsworth Preston			2a DATE OF DEATH Month Day Year Dec. 26 1968			2b HOUR 4:15 PM					
3 SEX MALE		4 RACE white		5 DATE OF BIRTH January 8, 1889		6 AGE (in years last birthday) 79 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH HARFORD Md					
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b KIND OF BUSINESS OR INDUSTRY Grocery					
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland		13b CITY OR TOWN HARFORD		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2701 Rocks Rd.					
14 FATHER'S NAME John Ellsworth Preston			15 MOTHER'S M A D E N NAME Mary Markland								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO		16b SOCIAL SECURITY NO 217-01-3761-A		17 INFORMANT (wife) 838-6069 Mrs. Nellie H. Preston		Address 2701 Rocks Road Forest Hill, Maryland 21050					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia CA gall bladder</u> 1560 DUE TO, OR AS A CONSEQUENCE OF <u>e metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 12-13, 1968, to 12-26, 1968, that (I) (we) lost saw the deceased alive on Dec. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE W. A. Sadowsky M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c DATE SIGNED 12/26/68			
22d PHYSICIAN'S NAME (Type) W. A. SADOWSKY				22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 28, 1968		23c NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cemetery		23d LOCATION (City or Town) Hickory, Harford Co., Maryland		(County)		(State)	
24 FUNERAL DIRECTOR Joseph William Foster				ADDRESS 60 Brookway Williams St. Baltimore, Maryland 21014				25a RECD BY REGISTRAR DATE DEC 30 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

17624

17645

1 DECEASED NAME (Type or print) Elizabeth S. Schwartz		2a DATE OF DEATH Month Day Year Dec 11 1968		2b HOUR 2:45 PM
3. SEX Female	4 RACE Cau	5. DATE OF BIRTH 14 April 1905		6. AGE (In years last birthday) 63 YRS
7a BIRTHPLACE (State or foreign country) Odessa, Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford Md.	
10 CITY OR TOWN OF DEATH Aberdeen Proving Ground	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.	13b COUNTY Chester	13c CITY OR TOWN Lincoln	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Lincoln University
14. FATHER'S NAME First Middle Last Harry Siskind		15 MOTHER'S MAIDEN NAME First Middle Last Mollie		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	17 INFORMANT Benjamin Schwartz, Lincoln Univ., Lincoln, Pa.	
18 CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF <u>Polycythemia Vera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>294X</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <u>8 Oct</u> , 19 <u>68</u> , to <u>11 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.				
22b SIGNATURE <i>Phillip J. Roberts</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 11 Dec 68	
22d PHYSICIAN'S NAME (Type) PHILLIP ROBERTS, MAJ, MC		22e ADDRESS US Kirk Army Hosp, Aberdeen Prov Ground MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/16/68	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L Cem.	23d. LOCATION (City or Town) ARLINGTON, VA	(County) (State)
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 8501 14th St Wash., D.C.	DATE DEC 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 17625 CERTIFICATE OF DEATH 17645 </div>									
1. DECEASED-NAME (Type or print) First Middle Last <i>Missouri Ellen Scott</i>						2a. DATE OF DEATH Month Day Year <i>Dec 27 68</i>		2b. HOUR MIN <i>30 10 A</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>22 March 1893</i>		6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>HAURE DE GRACE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>			12a. USUAL OCCUPATION (K na at work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution) STATE <i>Md</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Churchville</i>		13d. STREET AND NUMBER <i>Route Box 44</i>	
14. FATHER'S NAME First Middle Last <i>Isom Mullins</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>MARY Rachel Hamilton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16b. SOCIAL SECURITY NO <i>215-42-7765-J1</i>			17. INFORMANT Address <i>Hiram Scott, Churchville, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the body + tail of the pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>the pancreas</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 months</i> <i>6 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>									
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>11-19-68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-19-68</i> to <i>12-27-68</i> , that (I) (we) last saw the deceased alive on <i>12-27-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>					22c. DATE SIGNED <i>12/28/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>					22e. ADDRESS <i>Haure de Grace, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>30 Dec. 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Aberdeen, (Harford Co.) Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>					25a. REC'D BY REGISTRAR <i>JAN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

17646

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

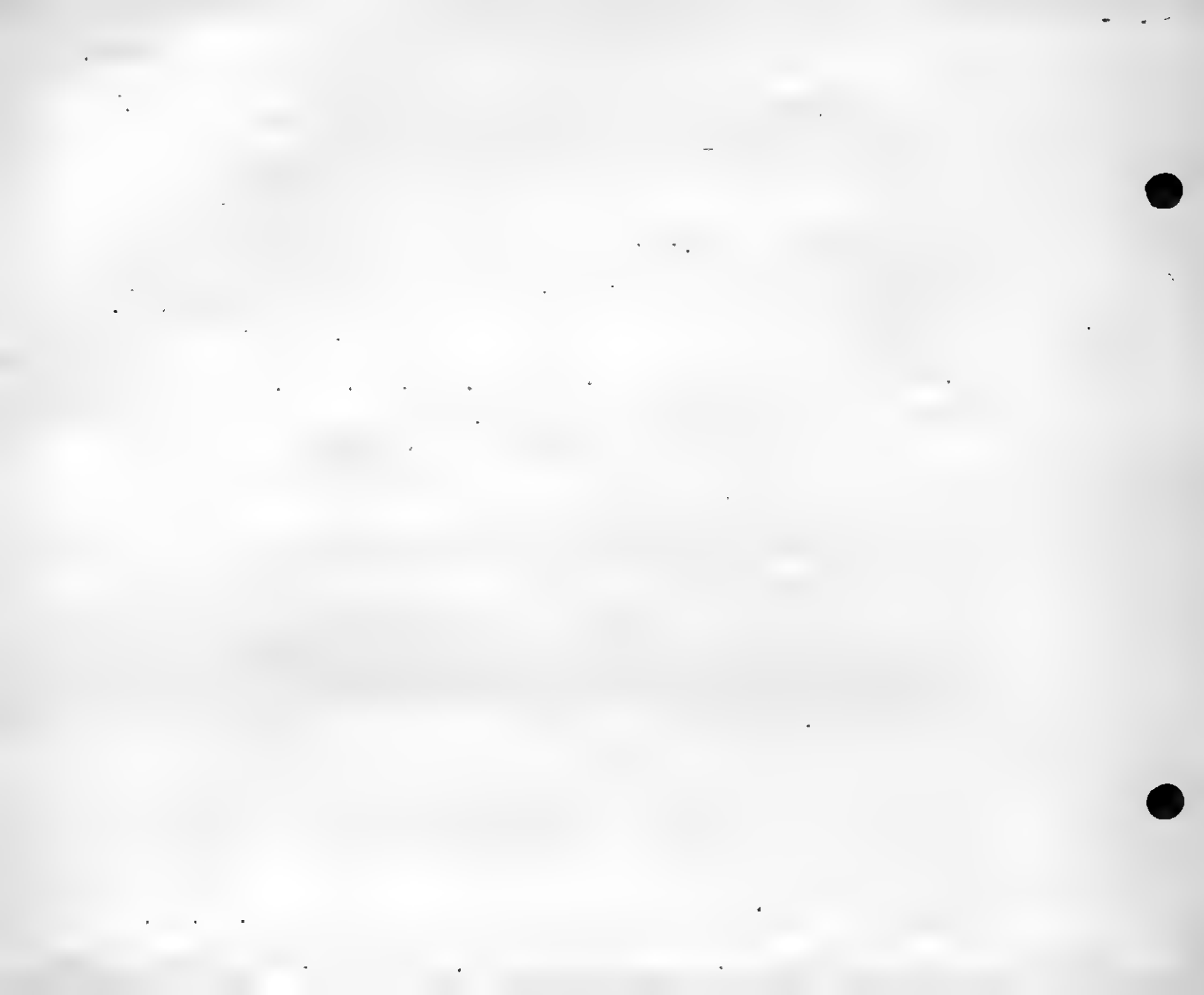
17647

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR					
Richard Lee Shaw								Dec 13		19		68		24		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
M		W		8-10-27		41 YRS		MONTHS		DAYS		Dec 13		19		68		24		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH													
Ohio		USA		W DOWED		DIVORCED		Harford													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY															
Havre de Grace		HARFORD MEMORIAL HOSPITAL		Hosp, Md.																	
13a. USUAL RESIDENCE (Where deceased lived, if institution)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
Md		Harford		Joppa		YES		542 Anchor Drive													
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
Ralph James Shaw								Ruth B. Shelton													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS															
Yes		218 26 3448		Mrs. Bertha B. Shaw.		542 Anchor Drive															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Fracture - Skull		DUE TO, OR AS A CONSEQUENCE OF		(b) Fracture L Femur		DUE TO, OR AS A CONSEQUENCE OF		(c) Fracture both bones Leg		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO													
21a. EXTERNAL CAUSE WAS PRIMARY		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		130		12-15-68		Auto Accident											
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County		State											
NOT WHILE AT WORK		Highway																			
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from.		Natural causes		Accident		Suicide		Homicide		Undetermined manner					
ACTUAL SIGNATURE		Gerald C Palmer		CHIEF MEDICAL EXAMINER		M.D.		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)		22b. DATE SIGNED		12-15-68					
EXAMINER'S NAME (Type)		Gerald C Palmer, M.D.																			
23a. BURIAL (Cremation, Removal (Specify))		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)											
Burial		12-18-68		Dulaney Valley Mem Gardens		Balto, Co. Md.															
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Johnson Funeral Home.		8521 Loch Raven Blvd.		21204		DEC 19 1968		Charles Judge													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Robert L. Smith								Month 12 Day 26 Year 1968			8:30 PM
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		5 January 1954				21 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				Harford					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Harford				Harford Memorial Hospital				Student		N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Harford		Aberdeen		YES		Rt #1 Aberdeen	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
First Middle Last Owen T. Smith				First Middle Last Margaret Powers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17 INFORMANT					
N/A				N/A		Margaret Powers, Aberdeen, Maryland					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure										1 hr	
485X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) (b) Broncho pneumonia										plus	
stating the underlying cause (c) DUE TO, OR AS A CONSEQUENCE OF											
lost Acute Upper Respiratory Infection										5 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Congenital Spastic Paralysis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
Oct 1968		Esophageal Atresia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-21, 1968, to 12-26, 1968, that (I) (we) last saw the deceased alive on 12-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
J. Ralph Horky		12/27/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
J. Ralph Horky, M.D.		Churchville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		29 Dec. 68		Harford Memorial Gardens		Aberdeen		Harford Co.,		Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tarring Funeral Home, Aberdeen, Md. 21001								DATE DEC 31 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17638		CERTIFICATE OF DEATH						17649			
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR		
Olivia N.M.N. Stansbury						Month Day Year 12 28 68			6:48 PM		
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		F UNDER 1 YEAR		
Female		Negro		30 May 1900			88 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.				Harford			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during 12 months of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Harre-de-Grace			Harford Memorial Hospital			Housewife					
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Md			Harford		Perryman						
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
George Stansbury			Sue								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT			Address			
No			212-32-4813		George Fisher Baltimore, Md			21217			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Bilateral Pneumonitis (Fulminating in Nature)											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Influenza with Bronchitis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Generalized Atherosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 12-28, 1968, to 12-28, 1968, that (I) (we) last saw the deceased alive on 12-28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		George T. Stansbury, M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
								12/29/68			
22d. PHYSICIAN'S NAME (Type)		George T. Stansbury, M.D.				22e. ADDRESS					
						569 Revolution St. Harre-de-Grace, Md.					
23a. BURIAL, CREMATION, REMAINS (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)		
Burial		3 Jan 69		Union Methodist Cemetery			R. D. Aberdeen, Md.		21001		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Kenneth B. Gargo, Tarring Funeral Home, Aberdeen, Maryland 21001				JAN 6 1969				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17600

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17650

1. DECEASED NAME (Type or print) Ollie O'Neal Stansbury			2a. DATE OF DEATH Month 12 Day 6 Year 1968			2b. HOUR 5:58 M P	
3. SEX Male		4. RACE Col.		5. DATE OF BIRTH June 24, 1905		6. AGE (In years lost birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY Harford		13c. CITY OR TOWN Perryman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME John W. Stansbury		15. MOTHER'S MAIDEN NAME Mary J. Pitt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 214-10-9225	
17. INFORMANT Mrs Bertha Mae Stansbury, Perryman, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized Arthritis Obesity							
19a. DATE OF OPERATION 4-4-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-23-1968 to 12-6-1968 , that (I) (we) lost saw the deceased alive on 12-6-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George T. Stansbury				22c. DATE SIGNED 12/9/68			
22d. PHYSICIAN'S NAME (Type) George T. Stansbury				22e. ADDRESS 569 Revolution St. Harre de Grace, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-11-1968		23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem		23d. LOCATION (City or Town) (County) (State) Abertown Harford Md.	
24. FUNERAL DIRECTOR Robert J. Bullock, Harre de Grace, Md.				25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17610

CERTIFICATE OF DEATH

17651

1 DECEASED-NAME (Type or print) First Middle Last Sylvia MAE Stewart			2a. DATE OF DEATH Month Day Year Dec. 14 1968			2b. HOUR 5:02 PM								
3 SEX Female		4 RACE Colored		5 DATE OF BIRTH April 16, 1925		6 AGE (In years last birthday) 43 YRS.		7 UNDER - YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN				
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.								
10 CITY OR TOWN OF DEATH HAURE de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp. Conowingo				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if not last an. Residence before admission) STATE Md.		13b COUNTY V		13c CITY OR TOWN Port Deposit		13d INSIDE CITY - MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 270 N. MAIN ST.						
14. FATHER'S NAME First Middle Last Morton C. Brown			15 MOTHER'S MAIDEN NAME First Middle Last Bertha L. Jones											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		16b. SOCIAL SECURITY NO. Unknown		17 INFORMANT Franklin H. Stewart Jr. Baltimore										
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Membranous glomerulonephritis (hypertensive) (b) (c) 6 months											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5918													DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic relapsing Pancreatitis														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from June 1968, to 12-14, 1968, that (I) (we) last saw the deceased alive on 12-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE John D. Yun						DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 12-14-68				
22d. PHYSICIAN'S NAME (Type) John D. Yun						22e ADDRESS HAURE DE GRACE, MD								
23a BURIAL-CREATION, REMOVAL (Specify)		23b DATE Dec. 18, 1968		23c NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d LOCATION (City or Town) (County) (State) Conowingo Cecil Md								
24c FUNERAL DIRECTOR Lee G. Patterson & Son, Inc.						ADDRESS Md		25a REC'D BY REGISTRAR DATE DEC 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) Blanche H. Street						2a. DATE OF DEATH Month 12 Day 2 Year 1968			2b. HOUR 6:55 M			
3. SEX F		4 RACE W		5. DATE OF BIRTH MAR. 30, 1890			6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a BIRTHPLACE (State or foreign country) VERMONT		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford Md						
10 CITY OR TOWN OF DEATH Harve de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial House				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE		12b KIND OF BUSINESS OR INDUSTRY HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD				13b COUNTY Harford		13c CITY OR TOWN Harve de Grace		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 551 Congress Ave		
14 FATHER'S NAME First HIRAM Middle WILDER Last LUCY BRADDISH				15 MOTHER'S MAIDEN NAME First LUCY Middle BRADDISH Last BRADDISH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown - (If yes give war or dates of service)				16b SOCIAL SECURITY NO 219-56-3382		17 INFORMANT ELMERR R. STREET		Address HARVE DE GRACE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Cardiac failure. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7824												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Nov. 22, 1967 , to Dec. 2, 1968 , that (I) (we) lost saw the deceased alive on Nov. 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Curt Finch				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12-2-68				
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS								
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-5-68		23c NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d LOCATION (City or Town) (County) (State) HARVE DE GRACE HARFORD, MD.						
24 FUNERAL DIRECTOR R. Madison Mitchell				ADDRESS Harve de Grace, Md.		25a REC'D BY REGISTRAR DEC 6 1968		25b REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Cheryl Lynn STURTEVANT		2a DATE OF DEATH December 23 1968		2b HOUR 10:30 AM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 12-23-68		6 AGE (in years last birthday) 6	7 MONTHS 0
7a BIRTHPLACE (State or foreign country) MD	7b CITIZEN OF WHAT COUNTRY? m USA.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Harford		
10 CITY OR TOWN OF DEATH HAUREDE GRACE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial Hosp.		12a USUAL OCCUPATION (Kind of work done during most of life, even if retired) Infant	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b COUNTY Harford	13c CITY OR TOWN Aberdeen	13d STREET AND NUMBER 347 Graceford Drive	
14 FATHER'S NAME Donn Elbert STURTEVANT		15 MOTHER'S MAIDEN NAME Diane Estelle Tidwell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b SOCIAL SECURITY NO None		17 INFORMANT Grace E. Sturtevant, Aberdeen, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Pulmonary Atelectasis					
DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity					
DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Heart Disease					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 71-25					
19a DATE OF OPERATION 71-25		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from 12-23, 1968 , to 12-23, 1968 , that (I) (we) last saw the deceased alive on 12-23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Glenn G. Conejero M.D.		22c DATE SIGNED 12-24-68		22d PHYSICIAN'S NAME (Type) Glenn G. Conejero M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 26 Dec. 68		23c NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens	
23d LOCATION (City or Town) Aberdeen		23e LOCATION (County) (Harford Co.)		23f LOCATION (State) Md.	
24 FUNERAL DIRECTOR Tarring Funeral Home		24b ADDRESS Aberdeen, Md. 21001		25a REC'D BY REGISTRAR DEC 27 1968	
25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR	
William Joseph Teyhan									December 28, 1968			7am	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		April 17, 1905				63 YRS					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
New York, N.Y.			U.S.A.						Harford County, Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Bel Air (Rural)			14 Northridge Drive			Supervisor			Banking				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Harford		Bel Air				14 Northridge Drive				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Joseph Francis Teyhan									Catherine Dalton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT (Step-Son) 676-2396 1013 Plaza Circle			Joppa, Md. 21085				
Yes			W.W. #2			059-10-4988			Mr. William D. Atkinson, Jr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u>												3 yrs	
4129 DUE TO, OR AS A CONSEQUENCE OF <u>AS HD</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>PRESENT</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Am Estrada MD</u>			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12-28-68</u>						
22d. PHYSICIAN'S NAME (Type) <u>ANTONIO M. ESTRADA</u>			22e. ADDRESS <u>45 N. Main St. Bel Air, Md. 21014</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Dec. 31, 1968		Bel Air Memorial Gardens			Bel Air, Harf. Co., Md. 21014					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>			West Broadway & Williams Bel Air, Md. 21014			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
						DATE <u>DEC 31 1968</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

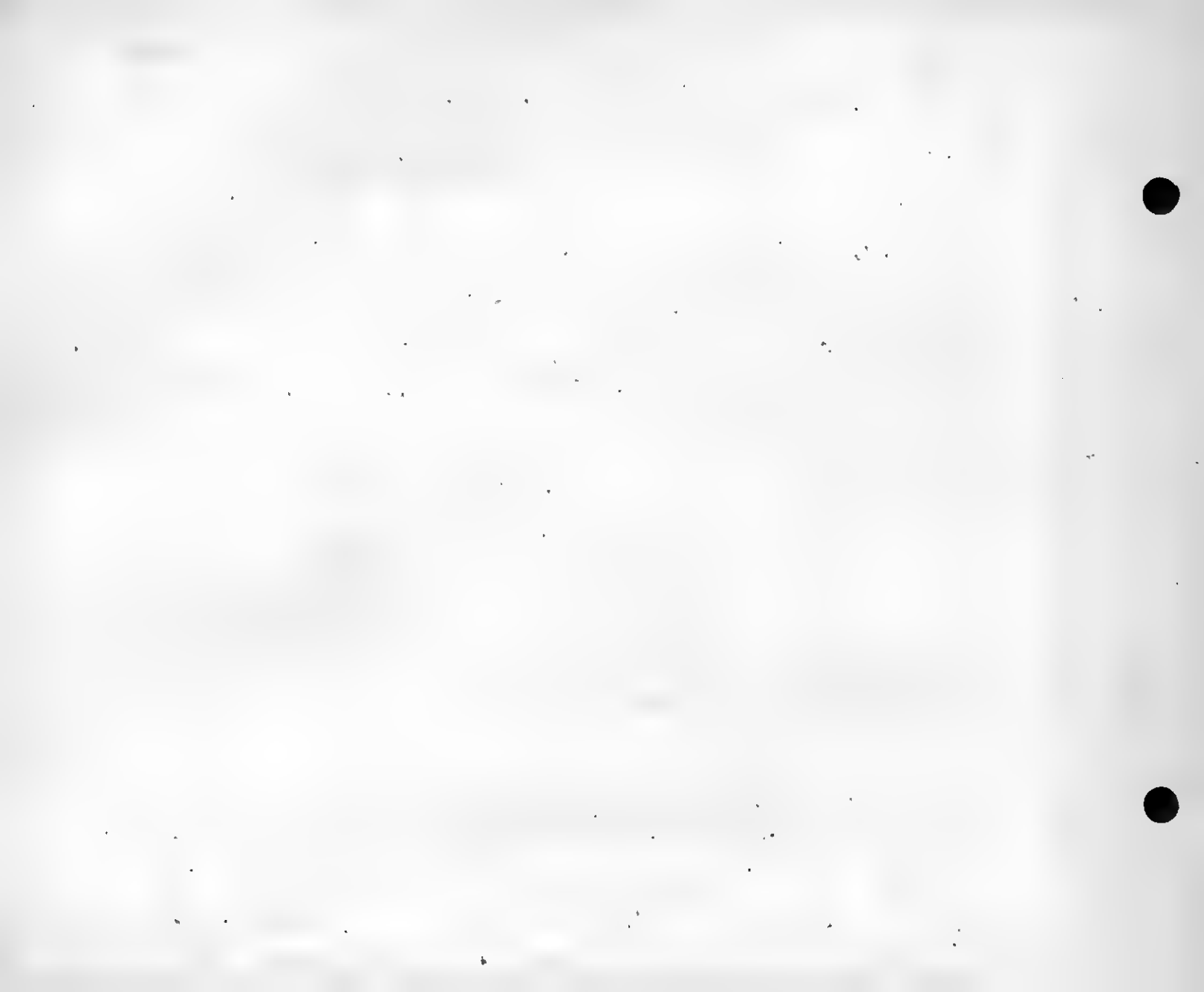
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17655

17655

1 DECEASED-NAME (Type or print) ROY JACOBSON THOMAS			2a. DATE OF DEATH Month DEC. Day 20 Year 1968			2b. HO. JR. 3rd			
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH FEB. 25 1888		6 AGE (in years last birthday) 80 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1123 POST ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED CONTRACT MAILER		12b. KIND OF BUSINESS OR INDUSTRY U.S. POST OFFICE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1123 POST ROAD	
14. FATHER'S NAME First JOHN Middle THOMAS Last AMANDA			15. MOTHER'S MAIDEN NAME First LEWIS Middle LEWIS Last LEWIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO 166-01-0359		17. INFORMANT CARL J. THOMAS		Address 1123 POST ROAD HAVRE DE GRACE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Coronary occlusion (c) Coronary occlusion									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4109									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Judge MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-21-68			
22d. PHYSICIAN'S NAME (Type) Charles Judge MD		22e. ADDRESS Havre de Grace MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC 22 1968		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAVRE DE GRACE MD			
24. FUNERAL DIRECTOR R. Madison Mitchell		ADDRESS HAVRE DE GRACE MD		25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17655

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17656

1 DECEASED NAME (Type or Print) Kenneth B. Todd Jr			2a DATE KNOWN OF DEATH Month 12 Day 26 Year 1968			2b HOUR 3:30
3 SEX M	4 RACE W	5 DATE OF BIRTH 9/19/1919	6 AGE (In years last birthday) 49 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	7 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month Dec Day 26 Year 1968
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford
10. CITY OR TOWN OF DEATH Harford		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done or last of working life, even if retired) Gas & Electric		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Harford		14 STREET AND NUMBER Jarrettsville, Road		
14 FATHER'S NAME First Kenneth B. Middle Todd Last Todd			15 MOTHER'S MAIDEN NAME First Grace Middle Windsor Last Windsor			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO 219-07-9265		17 INFORMANT Mrs. Mary C. Todd		ADDRESS Box 691 Forest Hill, Md 21050
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1-21						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion						
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.		22b DATE SIGNED 12-26-68		
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/30/1968		23c NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Charles E. Kurtz				25a REC'D BY REG STRAR DEC 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, within 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17657

17657

1 DECEASED-NAME (Type or Print) <u>Florence</u> First <u>Victor</u> Middle Last			2a DATE KNOWN OF ESTI. <input type="checkbox"/> Month <u>19</u> Day <u>7</u> Year <u>1968</u>			2b HOUR M <u>10</u>																	
3 SEX <u>F</u>			4 RACE <u>C</u>			5 DATE OF BIRTH <u>5-31-01</u>			6 AGE (in years last birthday) <u>67</u> YRS			7 IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>			8 IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>			2c DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>7</u> Year <u>1968</u>			2d HOUR M <u>10</u>		
7a BIRTHPLACE (State or foreign country) <u>Bolton, Ala</u>			7b CIT ZEN OF WHAT COUNTRY? <u>U. S. A.</u>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Harford</u>														
10 CITY OR TOWN OF DEATH <u>Harville de Grace</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <u>Old Bay Farm</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>ma</u>			12b KIND OF BUSINESS OR INDUSTRY <u>A.P.H.</u>														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md.</u>			13b COUNTY <u>Harford</u>			13c CITY OR TOWN <u>Harville de Grace</u>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <u>Old Bay Farm Race Track Road.</u>											
14 FATHER'S NAME First <u>Unknown</u> Middle <u>Unknown</u> Last <u>Unknown</u>			15 MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u>Unknown</u> Last <u>Unknown</u>																				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16b SOCIAL SECURITY NO (If yes give war or dates of service) <u>264-22-5714</u>			17 INFORMANT <u>Mrs. Dorothy L. Muckelbauer</u>			ADDRESS <u>Paul Dr. Superior St. Hales, Md.</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>+</u>																							
19a. DATE OF OPERATION <u>12-13-68</u>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year P.M. <u>19</u>						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____											
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Ary Md.</u>						22b DATE SIGNED <u>12-9-68</u>											
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county) _____											
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b DATE <u>12-13-68</u>						23c NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>						23d LOCATION (City or Town) <u>Washington</u> (County) <u>Harford</u> (State) <u>Md.</u>					
24 FUNERAL DIRECTOR <u>Stella J. Bullock</u>						ADDRESS <u>5562 Leno Ave</u>						25b REC'D BY REGISTRAR <u>Charles Judge</u>						25c REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>DEC 16 1968</u>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Chester Andrew Wallace		2a. DATE OF DEATH Month Day Year Dec. 26 1968		2b. HOUR 10 A M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH FEB. 2, 1897	
6. AGE (In years last birthday) 71 YRS		7. IF UNDER YEAR MONTHS DAYS 15		8. IF UNDER 24 HRS. HOURS MIN 10	
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH HARFORD		10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER F.I.D.		12b. KIND OF BUSINESS OR INDUSTRY FARMING		13. CITY OR TOWN OF RESIDENCE ROCKS	
13a. USJA. RESIDENCE (Where deceased lived, if institution or residence before admission) STATE Md.		13b. COUNTY Harford		13c. STREET AND NUMBER 1350 N. 1st St.	
14. FATHER'S NAME First Middle Last FRANK Wallace		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca MURRAY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO. 2-17-14-9991		17. INFORMANT Miss Ruth Wallace		Address Harford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Decomposition DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Disease		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 12/25/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19	
21c. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21d. LOCATION Street or R.F.D. No. City or Town County State Harford Md.		21e. SIGNATURE DAVIDE W. MONAKIL, M.D.	
21f. PHYSICIAN'S NAME (Type) DAVIDE W. MONAKIL, M.D.		21g. ADDRESS 211 N. Union Ave. Harford, Md.		21h. DATE SIGNED DEC 31 1968	
22a. I certify that (I) (this hospital) attended the deceased from 12/25 , 19 68 , to 12/26 , 19 68 , that (I) (we) last saw the deceased alive on 12/26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DAVIDE W. MONAKIL, M.D.		22c. DATE SIGNED DEC 31 1968	
22d. SIGNATURE DAVIDE W. MONAKIL, M.D.		22e. ADDRESS 211 N. Union Ave. Harford, Md.		22f. DATE SIGNED DEC 31 1968	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE Dec 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Westmont Grove	
23d. LOCATION (City or Town) (County) (State) Rocky Harford Md.		23e. RECD BY REGISTRAR John H. Perkins / C.H.H.		23f. REGISTRAR'S SIGNATURE John H. Perkins	
23g. DATE DEC 31 1968		23h. RECD BY REGISTRAR John H. Perkins		23i. REGISTRAR'S SIGNATURE John H. Perkins	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17648		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17659	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Sallie</i>		First		Middle		Last	
2a. DATE OF DEATH Month <i>December</i> Day <i>29</i> Year <i>1968</i>		2b. HOUR <i>12:15 PM</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>February 16, 1895</i>		6 AGE (In years last birthday) <i>73</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>NC.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Harford</i>	
10 CITY OR TOWN OF DEATH <i>HAURDE DE GRACE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>David</i> Middle <i>Cornett</i> Last <i>(D)</i>		15. MOTHER'S MAIDEN NAME First <i>Rebecca</i> Middle <i>Hamby</i> Last <i>(D)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>216-20-3841</i>		17. INFORMANT Address <i>Ruby Clark, 61 Baker St. Aberdeen, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompression, Sudden</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4231</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebral Artery Thrombosis, Pneumonia, GU Infection</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-21</i> , 19 <i>68</i> , to <i>12-29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-29-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dante M. Monakic, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/29/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DANTE M. MONAKIC, M.D.</i>		22e. ADDRESS <i>11 N. Main Ave Harford</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1 Jan. 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Aberdeen (Harford Co., Md.)</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

17649

CERTIFICATE OF DEATH

17660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Styrl NEWTON Wooddell			2a. DATE OF DEATH Month Dec. Day 30 Year 1968			2b. HOUR 11:43 AM					
3. SEX M		4. RACE W		5. DATE OF BIRTH Dec 27, 1921		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) W. Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Harvee de Gence		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Automotive Govt		12b. KIND OF BUSINESS OR INDUSTRY Govt					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 2008 Beach St			
14. FATHER'S NAME First ODIE Middle WOODDELL Last 			15. MOTHER'S MAIDEN NAME First SADIE Middle KEIRN Last CURRAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. WWILL		17. INFORMANT Mr. Elouse Kate Wooddell		Address 2008 Beach St. Bel Air Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/8 12/8	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept 10 , 19 68 , to 12/30 , 19 68 , that (I) (we) last saw the deceased alive on 12/30/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm H. Wooddell				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/30/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/2/1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens Bel Air, Harford Md.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Greenington + Son				ADDRESS Harvee de Gence, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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4100 10.11.10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 17650 CERTIFICATE OF DEATH 17661 </div>									
1. DECEASED-NAME (Type or print) Agnes M			2a. DATE OF DEATH Dec 29 1968			2b. HOUR 7:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH January 20, 1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harre-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Harre-de-Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 88, R.D. # 2	
14. FATHER'S NAME First John Middle Bozek Last Bozek			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 4129			17. INFORMANT Address Albena Beekley, Havre de Grace, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Dis (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Coronary Arteriosclerosis (c) Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wk 1 yr 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION 12-28-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 12-28-1968 City or Town 12-29-1968 County Harford State Md					
22a. I certify that (I) (this hospital) attended the deceased from 12-28-1968 to 12-29-1968 , that (I) (we) last saw the deceased alive on 12-28-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter P. Rodman		22c. DATE SIGNED 12-30-68		22d. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.					
22e. ADDRESS 8 Law St. Aberdeen, Maryland 21001									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 30 Dec. 68		23c. NAME OF CEMETERY OR CREMATORY St Stephens Polish Nat. Catholic		23d. LOCATION (City or Town) (County) (State) Reading, Penna			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

